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# **AUTONOMY AT THE END OF LIFE INFORMED CONSENT AND PASSIVE EUTHANASIA IN INDIAN CONSTITUTIONAL JURISPRUDENCE**

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## **Abstract**

Modern critical-care medicine has decoupled biological survival from the conscious, dignified human experience it was meant to serve, exposing a tension between therapeutic capability and human dignity. This chapter examines the constitutional foundations of patient autonomy, informed consent and passive euthanasia in Indian law, asking whether the guarantee of dignity, autonomy and privacy under Article 21 of the Constitution encompasses the right of a competent adult to refuse life-sustaining treatment and to choose a dignified death. Tracing the Supreme Court's trajectory from *P. Rathinam* through *Gian Kaur* and *Aruna Shanbaug* to the Constitution Bench in *Common Cause* and its 2023 procedural modification, it defends the thesis that the protection of life under Article 21 is qualitative rather than merely quantitative, and that an informed refusal of futile intervention is an exercise of bodily integrity that the State is bound to respect. To guard against coercion of vulnerable patients, the chapter argues for regulation rather than prohibition, drawing on comparative frameworks in the United Kingdom, Canada and the civil-law jurisdictions, and confronting objections grounded in disability rights and distributive justice. It concludes with constitutionally grounded recommendations for operationalising Advance Medical Directives in India.

**Keywords:** *Article 21; patient autonomy; informed consent; passive euthanasia; advance medical directives; Common Cause; constitutional morality.*

## **1. Introduction**

For most of legal history the cessation of respiration and cardiac function marked the unambiguous boundary of death. The mid-twentieth-century arrival of mechanical ventilation, cardiopulmonary resuscitation and artificial nutrition dissolved that boundary, allowing somatic functions to be sustained long after cognitive life has ended or recovery has become

impossible.<sup>1</sup> The decisive contemporary question is therefore no longer how medicine may preserve life, but when it must allow a person to die.

When biological survival is severed from dignified experience, the indefinite application of life-prolonging technology can become a form of medical tyranny, transforming the intensive-care unit into a site of institutionalised indignity. The continued maintenance of bare biological life can collide with the qualified, self-authored life that gives existence its meaning—the distinction the philosophical tradition marks between *zoē*, bare life, and *bios*, a life worth calling one's own.<sup>2</sup> This chapter locates the resolution of that collision in the constitutional architecture of Article 21, which provides that no person shall be deprived of life or personal liberty except according to procedure established by law.<sup>3</sup>

The central question is whether that guarantee includes a negative right: the right of a competent adult to refuse unwanted, life-sustaining treatment and to die a natural death through passive euthanasia. The enquiry is doctrinal, comparative and socio-legal. Its scope is deliberately confined to *passive* euthanasia—the withholding or withdrawal of life-sustaining treatment, allowing a patient to die of the underlying pathology—and to the operation of Advance Medical Directives (AMDs). It neither defends active euthanasia (the administration of a lethal agent) nor physician-assisted suicide, locating the refusal of treatment within the settled doctrine of informed consent: the right to decline intervention is an inseparable component of bodily integrity and constitutional liberty.

The stakes are acute in India. A vast and under-insured population, a chronic deficit of palliative-care capacity, and a decision-making culture in which the individual patient is rarely the sole interlocutor combine to make end-of-life law a question of social justice as much as of abstract liberty.<sup>4</sup> The argument accordingly proceeds from the doctrinal evolution of the right, through its grounding in autonomy and informed consent, to a constitutional and comparative

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<sup>1</sup>On the redefinition of death and its legal consequences see President's Commission for the Study of Ethical Problems in Medicine, *Defining Death* (US Government Printing Office 1981); for the Indian discussion, Aruna Ramachandra Shanbaug v Union of India (2011) 4 SCC 454 [16]-[38].

<sup>2</sup>Giorgio Agamben, *Homo Sacer: Sovereign Power and Bare Life* (Daniel Heller-Roazen tr, Stanford University Press 1998) 1-12, glossing Aristotle's distinction between *zoē* (bare biological life common to all living beings) and *bios* (a qualified form of life proper to an individual). The two terms are frequently transposed in legal writing; the usage here follows Aristotle and Agamben.

<sup>3</sup>Constitution of India 1950, art 21.

<sup>4</sup>On the palliative-care deficit see The Economist Intelligence Unit, *The 2015 Quality of Death Index* (2015) (ranking India among the lowest of the surveyed states for end-of-life care); Lancet Commission on the Value of Death, 'Bringing Death Back into Life' (2022) 399 *The Lancet* 837.

appraisal and a set of institutional proposals sensitive to that inequality.

Three terminological clarifications discipline the analysis. *Medical futility* denotes intervention incapable of reversing the underlying pathology or restoring awareness, serving only to defer somatic death; a *permanent vegetative state* is the irreversible loss of cortical function with retained brain-stem activity; and the law treats the *withholding* and the *withdrawal* of treatment as morally and legally equivalent, since a duty to continue a futile intervention cannot arise merely because it has begun.<sup>5</sup> These distinctions matter because much resistance to passive euthanasia rests on an intuition that withdrawing a ventilator is an 'act' of killing whereas withholding it is not—an intuition the equivalence thesis, and the immunity analysis developed below, dissolve.

## **2. The Evolution of Passive Euthanasia in India**

Indian courts long approached end-of-life choice through the reductive prism of criminal law, conflating the autonomous refusal of treatment with the offence of attempted suicide under section 309 of the Indian Penal Code 1860.<sup>6</sup> Dismantling that conflation required a reinterpretation of Article 21. The first stirring came in *P. Rathinam v Union of India*, where a two-judge Bench struck down section 309 and reasoned that the right to live carried a negative counterpart—a right not to live—by analogy with freedoms such as speech, which includes the right to remain silent.<sup>7</sup> The construction of an undifferentiated 'right to die' was, however, conceptually unstable.

It was overruled two years later by a five-judge Constitution Bench in *Gian Kaur v State of Punjab*, which held that the right to life is a guarantee of existence with human dignity and cannot be read to include its own extinction.<sup>8</sup> Yet the Court drew a careful distinction that would prove generative: the right to live with dignity extends to dignity in the process of dying, so that withdrawing artificial support from a patient whose death is imminent and inevitable is

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<sup>5</sup>On the equivalence of withholding and withdrawing see *Airedale NHS Trust v Bland* [1993] AC 789 (HL) 858 (Lord Keith), 867 (Lord Goff); General Medical Council, *Treatment and Care towards the End of Life* (2010) [4]. On futility and PVS see the clinical synthesis in *Aruna Shanbaug* (n 1) [16]-[38].

<sup>6</sup>Indian Penal Code 1860, s 309 (attempt to commit suicide). The provision has since been substantially superseded: Mental Healthcare Act 2017, s 115(1) presumes severe stress and bars trial and punishment under s 309; and the *Bharatiya Nyaya Sanhita* 2023, which replaced the Penal Code with effect from 1 July 2024, omits a general offence of attempted suicide, retaining only the narrow offence in s 226 (attempt to suicide to compel or restrain a public servant).

<sup>7</sup>*P. Rathinam v Union of India* (1994) 3 SCC 394 [35], [48]. The speech analogy was later criticised as a category error: the freedom not to speak preserves the speaker, whereas a 'right to die' extinguishes the right-holder.

<sup>8</sup>*Gian Kaur v State of Punjab* (1996) 2 SCC 648 [22]-[25].

merely to let nature take its course, not to curtail the natural span of life.<sup>9</sup> *Gian Kaur* thus rejected a general right to die while planting the doctrinal seed of a dignified death.

That seed was operationalised in *Aruna Ramachandra Shanbaug v Union of India*, concerning a nurse who had survived in a permanent vegetative state for nearly four decades after a brutal assault. Though the two-judge Bench declined the specific plea—because the hospital staff, acting *in loco parentis*, wished to continue her care—it permitted passive euthanasia in principle, subject to sanction by the High Court under Article 226.<sup>10</sup> The decision carried three weaknesses. It mistakenly suggested that *Gian Kaur* had not settled the question of passive euthanasia; it rested the active/passive line on an act–omission dichotomy widely doubted in the bioethical literature;<sup>11</sup> and it erected a case-by-case judicial procedure too cumbersome for the bedside.

The Constitution Bench in *Common Cause v Union of India* supplied the coherent foundation. Holding that the right to die with dignity is intrinsic to the right to life, it decoupled passive euthanasia from suicide—in the former the proximate cause of death is the underlying pathology, in the latter a self-inflicted act—and elevated Advance Medical Directives from mere evidence to binding expressions of Article 21 autonomy that survive the onset of incapacity.<sup>12</sup> Recognising that the 2018 safeguards had proved unworkable, the Court substantially simplified them in 2023: it removed the requirement of countersignature by a Judicial Magistrate, permitted an AMD to be attested before a notary or gazetted officer in the presence of two witnesses, reduced the experience threshold for medical-board members, and imposed time limits on board decisions.<sup>13</sup> Table 1 summarises this trajectory.

The unanimity of *Common Cause* concealed a productive plurality of reasoning. Misra CJ (for himself and Khanwilkar J) grounded the right in dignity and the autonomy of the competent

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<sup>9</sup>ibid [24]-[25] ('the right to live with human dignity would mean the existence of such a right up to the end of natural life ... includ[ing] the right of a dying man to also die with dignity when his life is ebbing out', distinguished from curtailing the natural span).

<sup>10</sup>*Aruna Shanbaug* (n 1) [101]-[126] (permitting withdrawal of life support for incompetent patients subject to High Court approval), drawing heavily on *Airedale NHS Trust v Bland* [1993] AC 789 (HL).

<sup>11</sup>The classic critique is James Rachels, 'Active and Passive Euthanasia' (1975) 292 *New England Journal of Medicine* 78, arguing that the bare distinction between killing and letting die carries no independent moral weight.

<sup>12</sup>*Common Cause (A Regd Society) v Union of India* (2018) 5 SCC 1 [197]-[202] (Dipak Misra CJ), with concurrences by Sikri, Chandrachud and Bhushan JJ; on dignity in dying see especially the opinion of Chandrachud J [338]-[386].

<sup>13</sup>*Common Cause (A Regd Society) v Union of India* 2023 SCC OnLine SC 99 (order dated 24 January 2023) (modifying the procedural directions in *Common Cause* (n 11)); see also Roop Gursahani and others, 'Simplified Legal Procedure for End-of-Life Decisions in India' (2023) *Indian Journal of Critical Care Medicine*.

person; Sikri J emphasised the continuity of self-determination across incapacity; Chandrachud J developed the fullest account of dignity in dying, treating the refusal of futile treatment as the natural extension of the constitutional protection of bodily and decisional integrity; and Bhushan J anchored the conclusion in the futility of treatment and the patient's best interests.<sup>14</sup> That convergence matters: it means the right to refuse rests not on a single contestable premise but on the mutually reinforcing values of dignity, autonomy and non-maleficence.

**Table 1. The evolution of passive-euthanasia jurisprudence in India**

| Decision                    | Bench / year   | Doctrinal contribution  |
|-----------------------------|----------------|---|
| P. Rathinam                 | 2 judges, 1994 | Struck down s 309 IPC; posited an undifferentiated 'right to die' under art 21            |
| Gian Kaur                   | 5 judges, 1996 | Overruled P. Rathinam; recognised dignity in dying while rejecting a general right to die |
| Aruna Shanbaug              | 2 judges, 2011 | Permitted passive euthanasia for incompetent patients via High Court sanction             |
| Common Cause                | 5 judges, 2018 | Right to die with dignity as part of art 21; binding Advance Medical Directives           |
| Common Cause (modification) | 5 judges, 2023 | Simplified AMD execution (notary/gazetted officer) and medical-board procedure            |

Sources: judgments as cited; 2023 modification reported at 2023 SCC OnLine SC 99.

The significance of this arc is not merely procedural. The progressive disarming of section 309—through the presumption of severe stress in the Mental Healthcare Act 2017 and the omission of a general suicide-attempt offence in the Bharatiya Nyaya Sanhita 2023—has removed the doctrinal anxiety that once tethered end-of-life refusal to the criminal law.<sup>15</sup> The courts can now address the refusal of treatment in its own register—as an exercise of liberty—rather than as a quasi-criminal act to be excused. *Common Cause* both reflects and completes that shift.

<sup>14</sup>Common Cause (n 11) [156]-[202] (Misra CJ), [414]-[440] (Sikri J), [338]-[386] (Chandrachud J), [496]-[520] (Bhushan J). The convergence of four routes on a single conclusion gives the holding unusual doctrinal resilience.

<sup>15</sup>Mental Healthcare Act 2017, s 115(1); Bharatiya Nyaya Sanhita 2023, s 226. With attempted suicide effectively de-penalised, the historic conflation that animated P. Rathinam and Gian Kaur loses its statutory premise, leaving the refusal of treatment to be analysed in its proper register of autonomy rather than criminality.

### **3. Patient Autonomy as a Constitutional Value**

Autonomy is not a statutory privilege but a foundational value animating the structure of fundamental rights, manifesting in medical law as the twin principles of bodily integrity and decisional self-determination. Bodily integrity vests in every competent adult an exclusive sovereignty over the physical body—the common-law principle famously stated by Cardozo J that 'every human being of adult years and sound mind has a right to determine what shall be done with his own body'.<sup>16</sup> In Indian constitutional jurisprudence that right is absorbed into Article 21, so that an unconsented bodily intrusion—however paternalistic its motive—is a prima facie violation of constitutional liberty.

Decisional autonomy is the internal dimension of that freedom: the agency to make self-defining choices in accordance with one's values and beliefs. In *K.S. Puttaswamy v Union of India* the Court located privacy within Article 21 and tied it expressly to autonomy, recognising the individual's ability to control the vital aspects of life and a right to be let alone.<sup>17</sup> Applied to dying, privacy shields the patient–physician relationship from arbitrary interference and confirms that the State's interest in preserving life, though weighty, is not absolute.

It follows that a competent patient who declines treatment is not seeking death but refusing an intolerable state of enforced survival. To compel painful, invasive and futile procedures against a competent refusal is to treat the patient as an object rather than an end, offending the conception of dignity—the Kantian injunction to treat humanity never merely as a means—that underpins the constitutional order.<sup>18</sup> Liberty under Article 21 must mean more than freedom from physical chains; it must include the freedom not to be chained to a machine.

This negative structure is essential to the argument. The right asserted is not a right to be killed but a right against unwanted intervention—an immunity, in Hohfeldian terms, rather than a claim-right to assistance.<sup>19</sup> Recognising the refusal of treatment as an immunity explains why

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<sup>16</sup>*Schloendorff v Society of New York Hospital* 211 NY 125, 129-30; 105 NE 92, 93 (1914) (Cardozo J). The English courts reach the same result: *Re T (Adult: Refusal of Treatment)* [1993] Fam 95; *Re B (Adult: Refusal of Medical Treatment)* [2002] EWHC 429 (Fam).

<sup>17</sup>*K.S. Puttaswamy v Union of India* (2017) 10 SCC 1 [298], [323] (Chandrachud J), [521] (Bobde J). Decisional autonomy over the body is treated as a core facet of informational and bodily privacy alike.

<sup>18</sup>Immanuel Kant, *Groundwork of the Metaphysics of Morals* (Mary Gregor tr, CUP 1998) 37-38 (the Formula of Humanity); for its constitutional reception in India see *Common Cause* (n 11) [156]-[160].

<sup>19</sup>On the analytic distinction between a liberty/immunity against interference and a claim-right to positive assistance see Wesley N Hohfeld, 'Some Fundamental Legal Conceptions as Applied in Judicial Reasoning' (1913) 23 Yale LJ 16. It is this distinction that separates passive euthanasia from physician-assisted death.

it can be honoured without committing the State to any general 'right to die': the State is asked only to desist, not to act. It also explains why the competent patient's contemporaneous refusal is, in principle, unconditional, whereas decisions for the incompetent patient require the procedural scaffolding examined below.

#### **4. Informed Consent in Medical Law**

The constitutional principles of autonomy and bodily integrity find operational expression in the doctrine of informed consent, which legitimises medical intervention; absent valid consent, even routine treatment is in principle a battery.<sup>20</sup> Valid consent—or refusal—rests on four pillars: competence, voluntariness, disclosure and understanding (Table 2).

**Table 2. The four pillars of informed consent**

| Pillar                | Requirement   |
|-----------------------|---|
| Competence / capacity | The patient possesses the cognitive ability to receive, weigh and use the relevant information          |
| Voluntariness         | The decision is free from coercion, undue influence or duress   |
| Disclosure            | Adequate information on the nature, risks, benefits, alternatives and the consequences of non-treatment |
| Understanding         | Genuine comprehension of the information and of the foreseeable outcomes of the choice                  |

Source: synthesised from Beauchamp and Childress, *Principles of Biomedical Ethics* (8th edn, 2019) ch 4, and Samira Kohli (2008).

In *Samira Kohli v Dr Prabha Manchanda* the Supreme Court held that consent must be 'real and valid' and that the doctor must disclose enough to enable an informed choice. Significantly, the Court adopted the reasonably prudent *doctor* standard of disclosure derived from *Bolam*, declining—for the present—the more demanding prudent-*patient* standard of *Canterbury v Spence*.<sup>21</sup> Whatever the standard, the power to consent necessarily includes the power to refuse;

<sup>20</sup>On unconsented treatment as battery/assault see Schloendorff (n 14); for India, *Samira Kohli v Dr Prabha Manchanda* (2008) 2 SCC 1 [17]-[23].

<sup>21</sup>*Samira Kohli* (n 18) [26]-[32], adopting the standard in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 and declining the patient-centred test in *Canterbury v Spence* 464 F 2d 772 (DC Cir 1972). The contrast matters: the English law of disclosure has since moved to a patient-centred test in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, a direction Indian law may yet follow.

a right that permitted only agreement would be a contradiction. A competent patient's refusal of life-sustaining treatment is simply the negative expression of informed consent, and the physician's duty to honour it is as binding as the duty to obtain consent.

The difficulty arises when illness erodes capacity. To carry autonomy across that threshold the law relies on Advance Medical Directives and on substitute decision-making. An AMD is an instrument by which a competent person specifies the interventions to be accepted or refused should capacity later be lost; *Common Cause* validated AMDs as a direct projection of Article 21 into the future.<sup>22</sup> Where no directive exists, the law turns to substituted judgment—what this patient would have chosen, judged from prior values and expressions—or, failing that, to an objective assessment of best interests. In each case informed consent remains the governing frame, ensuring decisions are anchored in the patient's dignity rather than institutional convenience.

The 2023 modification gave this autonomy a workable institutional form. An AMD may now be executed by a competent adult, signed before two witnesses and attested by a notary or gazetted officer, with copies lodged for safekeeping; it takes effect only once treating physicians certify that the specified clinical condition has materialised.<sup>23</sup> A surrogate or health-care proxy may be nominated within the directive, converting the abstract doctrine of substituted judgment into a concrete, identifiable decision-maker. The reform narrows the gap between the constitutional recognition of autonomy and its clinical realisation—the gap in which the 2018 framework had foundered.

Capacity is the hinge on which the whole doctrine turns, and it must be assessed with care rather than assumed from diagnosis. The law presumes a competent adult to have capacity unless the contrary is shown, and capacity is decision-relative: a patient may be competent to refuse one intervention while incompetent as to another.<sup>24</sup> A refusal that appears self-destructive does not by itself rebut the presumption; it triggers, at most, a duty of careful

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<sup>22</sup>Common Cause (n 11) [202], [stage-wise guidelines]; the instrument is the Indian analogue of the Advance Decision to Refuse Treatment under the Mental Capacity Act 2005 (UK), ss 24-26.

<sup>23</sup>Common Cause (n 12) (modified guidelines on execution, custody and activation of the directive). The earlier requirement of countersignature by a Judicial Magistrate of the First Class was the principal cause of the directive's dormancy between 2018 and 2023.

<sup>24</sup>Re MB (Medical Treatment) [1997] 2 FLR 426; Mental Capacity Act 2005 (UK), ss 1-3 (presumption of capacity; decision-specific, functional test). The Mental Healthcare Act 2017 (India), s 4, adopts a similar capacity standard turning on the ability to understand, retain, use and communicate.

inquiry. The constitutional and clinical task is to distinguish an autonomous, value-driven refusal from a decision distorted by treatable depression, pain or misinformation—an inquiry that protects autonomy and the vulnerable simultaneously, and which the procedural safeguards below are designed to institutionalise.

## **5. Constitutional Analysis**

### **5.1 Article 21: the qualitative dimension of life**

Since *Maneka Gandhi v Union of India* it has been settled that 'life' in Article 21 is not mere animal existence, and in *Francis Coralie Mullin* the Court held that it embraces the right to live with human dignity and all that makes life meaningful.<sup>25</sup> Read with the privacy holding in *Puttaswamy*, these authorities establish that decisional autonomy over one's body—including the manner of one's final days, free from un-consented technology—lies at the centre of the protected sphere. Where terminal illness subjects a patient to intractable suffering and strips away cognitive agency, compelling continued mechanical maintenance can itself violate the dignity Article 21 protects.

The dignity at stake is not contingent on the patient's residual capacities; it is the intrinsic, non-instrumental worth of the person. The objection that recognising a dignified death 'devalues' the lives of the severely disabled mistakes the structure of the right. What Article 21 protects is the patient's own appraisal of what an acceptable life is; it does not authorise the State, or anyone else, to judge a life not worth living. The autonomy reading is thus the opposite of a quality-of-life calculus imposed from without: it forbids precisely the external judgment the disability critique fears, vesting the assessment of tolerability in the patient alone.

### **5.2 Article 14: non-arbitrariness and proportionality**

Article 14 forbids manifestly arbitrary State action and, since *Modern Dental College* and *Puttaswamy*, subjects rights-limiting measures to a structured proportionality test: legitimate aim, rational connection, necessity (least-restrictive means) and a fair balance between the limitation and its purpose.<sup>26</sup> A regime that bans passive euthanasia outright, or hedges it with procedures so cumbersome as to be functionally inaccessible—as the 2018 guidelines proved to be—fails this test: it inflicts severe suffering to secure a protective aim that less restrictive

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<sup>25</sup>*Maneka Gandhi v Union of India* (1978) 1 SCC 248 [5]-[7]; *Francis Coralie Mullin v Administrator, Union Territory of Delhi* (1981) 1 SCC 608 [7]-[8] (life means more than mere animal existence).

<sup>26</sup>*Modern Dental College & Research Centre v State of Madhya Pradesh* (2016) 7 SCC 353 [60]-[65]; *K.S. Puttaswamy* (n 15) [310], [638] (proportionality as the standard for limiting fundamental rights).

means, such as independent medical boards, can achieve. The 2023 modification is best understood as a proportionality correction.

Applied concretely, proportionality cuts both ways and thereby disciplines reform. A magistrate's countersignature for every living will pursued a legitimate anti-abuse aim but flunked the necessity limb, because attestation before a notary or gazetted officer—coupled with witnessing and registry safeguards—achieves the same protective purpose at a fraction of the burden.<sup>27</sup> Conversely, the same test forbids dismantling safeguards altogether: a framework with no independent review would fail the balancing limb by leaving the vulnerable exposed. Proportionality thus supplies a principled equilibrium—neither the bureaucratic paralysis of 2018 nor an unprotected free-for-all—that the institutional design in Part 9 seeks to capture.

### **5.3 Article 19, procedural due process and constitutional morality**

The freedoms in Article 19 presuppose a baseline of autonomous personal agency, and State action forcing a competent adult to submit to unwanted treatment can be justified only on the narrow grounds the Article enumerates—none of which is engaged by a private patient declining treatment in a hospital room. 'Public morality' cannot be deployed to impose a majoritarian vitalist ethic on a dissenting individual.<sup>28</sup> Since *Maneka Gandhi*, 'procedure established by law' has meant procedure that is just, fair and reasonable; a framework for passive euthanasia must reconcile the State's respect for autonomy with its *parens patriae* duty to protect the vulnerable. That reconciliation must be governed by constitutional morality—adherence to liberty, equality and fraternity even against entrenched social or religious sentiment—rather than majoritarian morality.<sup>29</sup>

A federalism caveat conditions any reform. Public health and hospitals are State subjects under Entry 6 of List II, while the criminal law and the regulation of the medical profession are shared or Union concerns; the *Common Cause* guidelines, issued under Article 142, therefore operate against a divided legislative competence.<sup>30</sup> A durable framework consequently requires cooperative action: a Union framework statute supplying definitions, immunities and minimum

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<sup>27</sup>Common Cause (n 12); the analysis mirrors the structured proportionality enquiry in *Modern Dental College* (n 23) and *Anuradha Bhasin v Union of India* (2020) 3 SCC 637 [60]-[75] (necessity and the least-restrictive-means enquiry).

<sup>28</sup>On the limits of public morality as a ground of restriction see *Navtej Singh Johar v Union of India* (2018) 10 SCC 1 [253], [638] (constitutional morality prevails over popular morality).

<sup>29</sup>On constitutional morality see B.R. Ambedkar, *Constituent Assembly Debates* (Vol VII, 4 November 1948); applied in *Common Cause* (n 11) and *Navtej Johar* (n 24). The State may not enforce a sectarian 'sanctity of life' doctrine so as to override individual bodily self-determination.

<sup>30</sup>Constitution of India 1950, Seventh Schedule, List II Entry 6 (public health and hospitals), List III Entries 1 and 26 (criminal law; medical profession). On the limits of judicial guidelines as a substitute for legislation see *Vishaka v State of Rajasthan* (1997) 6 SCC 241 [16].

safeguards, implemented through State rules adapted to local institutional capacity. Reliance on judicial guidelines alone leaves the right resting on the fragile foundation of continuing curial supervision rather than democratic enactment.

## **6. Medical Ethics and End-of-Life Decisions**

The legal framework operates in dialogue with the four principles of biomedical ethics—respect for autonomy, beneficence, non-maleficence and justice.<sup>31</sup> Medicine's older paternalism, which let the physician determine the patient's 'best interest' and prized the prolongation of life at all costs, has yielded to the primacy of autonomy: the patient, not the clinician, is the arbiter of what suffering is tolerable. When treatment becomes futile—unable to reverse the pathology or restore awareness and serving only to defer somatic death—non-maleficence comes to the fore, and continued invasive intervention ceases to be therapeutic and becomes a harm.<sup>32</sup> Justice adds a distributive dimension: in a system where intensive-care capacity is scarce, the futile maintenance of an irreversibly terminal patient withholds those resources from others who might recover—so that a regulated framework can align individual autonomy with distributive fairness, provided scarcity is never permitted to drive the clinical judgment of futility.

Two conceptual devices have historically done the work of reconciling non-maleficence with the relief of suffering, and both warrant scrutiny. The first is the act–omission distinction, on which *Bland* and *Aruna Shanbaug* relied; the second is the doctrine of double effect, which permits the administration of analgesia foreseeably hastening death provided the intention is to relieve pain.<sup>33</sup> Both distinctions are philosophically contestable, yet they perform an important limiting function: they confine the lawful conduct to the withdrawal of futile intervention and the proportionate relief of suffering, stopping short of intentional killing. For a jurisdiction that has chosen, for now, to permit only passive euthanasia, these distinctions are not mere sophistry but the conceptual boundary markers of the permitted zone.

The principle of justice must, however, be handled with particular care in the Indian setting.

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<sup>31</sup>Tom L Beauchamp and James F Childress, *Principles of Biomedical Ethics* (8th edn, OUP 2019) chs 4-7.

<sup>32</sup>On medical futility and the shift to non-maleficence see Dworkin's account of beneficent non-intervention in Ronald Dworkin, *Life's Dominion: An Argument About Abortion, Euthanasia, and Individual Freedom* (Knopf 1993) ch 7; and Jonathan Glover, *Causing Death and Saving Lives* (Penguin 1977) chs 10-15.

<sup>33</sup>On double effect see Beauchamp and Childress (n 22) ch 5; for judicial reception, *Airedale v Bland* (n 26) and *R v Cox* (1992) 12 BMLR 38. The doctrines are analytically fragile—Rachels (n 6)—but they remain the load-bearing distinctions of the passive model.

While the futile occupation of a scarce intensive-care bed has genuine distributive consequences, resource scarcity must never be permitted to contaminate the clinical judgment of futility, lest cost masquerade as prognosis and the poor be triaged toward death.<sup>34</sup> The defensible role of justice is systemic, not bedside: it argues for investment in palliative capacity and for transparent allocation rules, not for a lower threshold of futility in public hospitals than in private ones. Keeping these registers separate is essential if a dignified-death framework is not to become an instrument of rationing.

## **7. Comparative Constitutional Perspectives**

Comparative practice reveals a near-universal acceptance of the competent adult's right to refuse treatment, alongside divergent treatment of active termination. In the *United Kingdom*, the common law has long recognised an absolute right to refuse treatment, confirmed for the incompetent patient in *Airedale NHS Trust v Bland*, where the House of Lords held that withdrawing life support from a patient in a permanent vegetative state was lawful because continued treatment was futile and not in his best interests; the act–omission line was treated as decisive.<sup>35</sup> In *Canada*, the Supreme Court first upheld the prohibition on assisted dying in *Rodriguez*, then unanimously reversed course in *Carter*, holding the blanket ban a violation of section 7 of the Charter; Parliament responded with a statutory Medical Assistance in Dying regime.<sup>36</sup> The *United States* confirms the same asymmetry: a constitutionally protected liberty to refuse treatment in *Cruzan*, but no right to assisted suicide in *Glucksberg* and *Quill*.<sup>37</sup>

The *Netherlands* and *Belgium* mark the permissive pole, decriminalising active euthanasia and assisted suicide under strict 'due care' criteria—a voluntary, well-considered and enduring request and unbearable suffering without prospect of improvement—policed by retrospective multidisciplinary review committees.<sup>38</sup> For India, whose framework remains confined to

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<sup>34</sup>On the danger of allowing distributive pressures to drive individual clinical decisions see Norman Daniels, *Just Health: Meeting Health Needs Fairly* (CUP 2008) ch 4. The autonomy of the patient, not the economy of the ward, must remain the operative criterion.

<sup>35</sup>*Airedale NHS Trust v Bland* [1993] AC 789 (HL) 866-69 (Lord Goff). The position is now codified in the Mental Capacity Act 2005 (UK), ss 24-26 (advance decisions to refuse treatment) and ss 9-14 (lasting powers of attorney).

<sup>36</sup>*Rodriguez v British Columbia (AG)* [1993] 3 SCR 519; *Carter v Canada (AG)* 2015 SCC 5, [2015] 1 SCR 331 [56]-[71]; implemented by An Act to amend the Criminal Code (medical assistance in dying), SC 2016 c 3 (Bill C-14), expanded by SC 2021 c 2 (Bill C-7).

<sup>37</sup>*Cruzan v Director, Missouri Department of Health* 497 US 261 (1990); *Washington v Glucksberg* 521 US 702 (1997); *Vacco v Quill* 521 US 793 (1997). The European Court of Human Rights likewise found no right to assisted dying while recognising the autonomy interest: *Pretty v United Kingdom* (2002) 35 EHRR 1 [61]-[67].

<sup>38</sup>*Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002* (Netherlands); *Belgian Act on Euthanasia of 28 May 2002*. Both rely on regional review committees of legal, medical and ethical members.

passive euthanasia, the salient comparative lesson is institutional: the substantive right to refuse is universal, but its safe operation depends on clear, accessible, non-bureaucratic procedure. The UK's statutory codification and Canada's structured eligibility assessment both show that routine judicial involvement is unnecessary; *Aruna Shanbaug's* case-by-case High Court model was the avoidable error that *Common Cause* and its 2023 modification have progressively corrected. Table 3 sets out the comparison.

The European experience adds a cautionary nuance about institutional competence. The European Court of Human Rights has consistently held that, while Article 8 of the Convention protects the autonomy interest in decisions about one's own death, the absence of a European consensus leaves states a wide margin of appreciation—so that the *manner* of regulating end-of-life choice is largely a matter for national authorities.<sup>39</sup> *Lambert v France* is especially instructive for India: the Court upheld the withdrawal of artificial nutrition and hydration precisely because France possessed a clear legislative framework and a transparent collegiate procedure—underscoring that the constitutional legitimacy of withdrawal turns less on the substantive right, which is settled, than on the existence of fair, intelligible process. That is the lesson India's 2023 reform begins to absorb.

**Table 3. Comparative end-of-life frameworks**

| Jurisdiction   | Passive euthanasia    | Active / PAS                  | Principal instrument / safeguard                    |
|----------------|-----------------------|-------------------------------|---|
| India          | Lawful (Common Cause) | Not permitted                 | Advance Medical Directive; two-tier medical boards  |
| United Kingdom | Lawful (Bland)        | Not permitted                 | Mental Capacity Act 2005; advance decisions         |
| Canada         | Lawful                | Lawful (MAID)                 | Carter; Bills C-14 / C-7 eligibility safeguards     |
| United States  | Lawful (Cruzan)       | No general right (Glucksberg) | State living-will statutes; clear-evidence standard |

<sup>39</sup>*Pretty v UK* (n 21) [61]-[67]; *Haas v Switzerland* (2011) 53 EHRR 33 [51]-[55]; *Lambert v France* (2016) 62 EHRR 2 [144]-[148] (withdrawal of nutrition and hydration from a patient in a chronic vegetative state falls within the state's margin where a clear domestic legal framework and fair process exist).

|                       |        |                   |  |
|-----------------------|--------|-------------------|--|
| Netherlands / Belgium | Lawful | Lawful, regulated | 'Due care' criteria; retrospective review committees |
|-----------------------|--------|-------------------|--|

*Sources: judgments and statutes cited in the text. PAS = physician-assisted suicide; MAID = medical assistance in dying.*

Why, then, does India halt at passive euthanasia while Canada and the civil-law jurisdictions have moved further? The answer is partly constitutional and partly prudential. *Gian Kaur* forecloses a generalised right to die, and the act–omission framework supplies a principled stopping point that does not require the State to license intentional killing; the immunity-based reading developed above explains why the passive case is constitutionally easier, since it asks only for non-interference.<sup>40</sup> Prudentially, the very inequalities canvassed below counsel caution about extending the framework to active measures before the institutional safeguards for the passive case are secure. The sequence matters: a jurisdiction should master the governance of withdrawal before contemplating assistance in dying.

### **8. Challenges and Counterarguments**

The case for regulated passive euthanasia must withstand serious objections. The first is the vulnerability of the elderly and disabled: in a society with weak social security and entrenched familial hierarchies, a refusal of treatment may be shaped by pressure from relatives motivated by inheritance or the burden of care, so that the 'autonomous' choice is not genuinely free.<sup>41</sup> Disability-rights scholars, invoking the social model, warn that society's failure to provide support can make disabled life appear intolerable and that legalisation risks a slide from a right to die toward a perceived duty to die.<sup>42</sup>

These concerns are sharpened in India by stark inequality of access: most of the population lacks meaningful health insurance, and out-of-pocket expenditure is a leading driver of impoverishment, so that a family's decision to withdraw treatment may reflect financial

<sup>40</sup>Gian Kaur (n 7); Common Cause (n 11). The comparative trajectory of *Carter v Canada* (n 27) shows that the line between passive and active is politically, not logically, fixed—but moving it is a legislative choice requiring safeguards India has not yet built.

<sup>41</sup>On coercion risks see Law Commission of India, *Medical Treatment to Terminally Ill Patients (Protection of Patients and Medical Practitioners)*, Report No 196 (2006) ch VII; and the disability critique in Ezekiel J Emanuel and others, 'Attitudes and Practices of Euthanasia and Physician-Assisted Suicide' (2016) 316 JAMA 79.

<sup>42</sup>On the social model and the 'duty to die' concern see Alicia Ouellette, *Bioethics and Disability: Toward a Disability-Conscious Bioethics* (CUP 2011) chs 1-3.

desperation rather than a considered choice for a natural death.<sup>43</sup> A third cluster of objections is professional and religious: some clinicians regard participation in withdrawal as a breach of the Hippocratic commitment, and several religious traditions treat the timing of death as a divine prerogative.

None of these justifies a paternalistic, total prohibition, which would itself violate the constitutional rights of competent patients; each instead establishes the need for robust, layered safeguards. To deny an impoverished, terminally ill patient the right to refuse futile treatment does not repair the healthcare system—it adds a forced bodily violation to existing hardship. The constitutional response is to regulate, not prohibit: independent hospital boards, mandatory capacity and, where indicated, psychiatric assessment, protection for conscientious objection, and an absolute firewall between resource scarcity and the clinical determination of futility, can protect the vulnerable while honouring autonomy.

The religious objection requires a distinctively constitutional response. India's traditions are not monolithic on the matter: Jain *sallekhana*, the considered fast unto death, illustrates an indigenous acceptance of voluntary cessation that complicates any claim of a uniform 'sanctity of life' ethic.<sup>44</sup> More fundamentally, a secular State governed by constitutional morality may not enforce one community's metaphysics of death upon a dissenting individual. Religious conviction is a powerful reason for the believer to decline withdrawal for herself; it is not a constitutional warrant to compel continued treatment of another who holds a different view. The framework defended here is permissive, not mandatory: it enlarges the menu of dignified choices without obliging anyone to choose any particular one.

The disability critique deserves a more exacting answer than reassurance. Its force lies in the observation that a choice is only as free as the alternatives that frame it; where palliative care, home support and disability services are absent, a 'choice' to forgo treatment may be no choice at all.<sup>45</sup> The correct constitutional inference is not prohibition but a positive obligation: the

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<sup>43</sup>On catastrophic health expenditure in India see National Health Accounts Estimates for India 2019-20 (Ministry of Health and Family Welfare 2022); World Health Organization, Global Spending on Health 2021. Where withdrawal substitutes for affordable palliative care, it expresses structural injustice rather than dignity.

<sup>44</sup>On *sallekhana* and its legal contestation see Nikhil Soni v Union of India 2015 SCC OnLine Raj 2042 (Rajasthan HC), stayed by the Supreme Court pending appeal; and the discussion in Common Cause (n 11) on plural conceptions of a good death.

<sup>45</sup>On the conditions of meaningful autonomy see Joseph Raz, *The Morality of Freedom* (Clarendon Press 1986) ch 14 (autonomy presupposes an adequate range of valuable options). The disability objection is therefore best met not by denying the right but by guaranteeing the conditions in which its exercise is genuinely voluntary.

State's duty under Article 21 to provide accessible palliative care is the necessary condition of an autonomous refusal, and a withdrawal framework that operates without that guarantee risks ratifying structural injustice as individual choice. Regulation must therefore travel together with provision.

## **9. Recommendations**

Bridging constitutional principle and clinical reality requires a streamlined, secure and protective framework. The 2023 modification removed the most obstructive features of the 2018 regime, but it remains a set of judicial directions rather than a statute, and it presupposes an institutional and palliative infrastructure that much of the country lacks. The measures below therefore pursue three goals at once—statutory permanence, procedural accessibility, and protection of the vulnerable—on the premise that none can be sacrificed to the others without constitutional cost.

| # | Recommendation   | Rationale  |
|---|--|--|
| 1 | Enact a comprehensive End-of-Life Care and Patient Autonomy Act defining 'terminal illness', 'medical futility' and 'permanent vegetative state', and granting good-faith immunity to clinicians.        | Statutory permanence beyond Article 142 guidelines                 |
| 2 | Establish a secure national digital registry for Advance Medical Directives, integrated with the ABDM health ID, executable before a notary or gazetted officer and revocable at will.                   | Operationalises the 2023 modification; ensures bedside access      |
| 3 | Confine futility determination to a two-tier hospital board (primary treating team; independent secondary board with a CMO nominee and a legal/bioethics member), without routine judicial intervention. | Proportionality; accessibility (corrects Aruna Shanbaug)           |
| 4 | Require independent capacity and, where refusal may reflect treatable depression, psychiatric assessment.  | Distinguishes autonomy from clinical crisis; <i>parens patriae</i> |

|   |   |   |
|---|---|---|
| 5 | Mandate concurrent, comprehensive palliative care whenever life-sustaining treatment is withheld or withdrawn, and recognise a justiciable entitlement to palliative care under Article 21. | Dignity in dying includes a pain-free death; condition of genuine voluntariness |
| 6 | Protect clinicians' conscientious objection while imposing a duty to refer, so that objection never becomes obstruction of a patient's lawful choice.                                       | Reconciles professional conscience with patient autonomy                        |
| 7 | Require periodic public reporting and audit of board decisions to deter abuse and build institutional trust.  | Transparency; safeguard against coercion of the vulnerable                      |

Source: author's recommendations, building on *Common Cause* (2018) and its 2023 modification.

## **10. Conclusion**

The trajectory of Indian jurisprudence from *P. Rathinam* to the 2023 modification of *Common Cause* reflects a maturing recognition that the protection of life under Article 21 is qualitative, not a command to preserve cellular existence at all costs. A competent adult's refusal of futile, invasive treatment is not an abdication of life but an assertion of the dignity that defines it, and by anchoring that choice in informed consent the law has rightly severed passive euthanasia from criminal suicide. Yet constitutional validation cannot float free of India's socio-economic realities: the genuine risks of coercion and financial despair demand a cautious, tightly regulated and accessible procedure—simplified directives, independent multidisciplinary boards, and integrated palliative care. Built on those safeguards, Indian law can protect vulnerable lives from exploitation while allowing the individual to complete life's journey with dignity, reaffirming the Constitution as a living and humane document that protects liberty not only throughout life but in its final passage.

Two cautions temper this optimism. First, a right that exists only on paper is no right at all: the framework's legitimacy will be measured not by the elegance of its doctrine but by whether an ordinary patient in a district hospital can, in practice, have a valid directive honoured without litigation. Second, autonomy and protection are not opposed values to be traded off but mutually constitutive—genuine autonomy presupposes the absence of coercion, and

meaningful protection presupposes respect for the patient's own voice.<sup>46</sup> The task ahead is neither to treat *Common Cause* as a destination nor to dismiss its safeguards as obstruction, but to build the unglamorous scaffolding—registries, boards, palliative services and audit—on which a constitutional promise becomes a lived reality.

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<sup>46</sup>The point reflects the relational conception of autonomy in Catriona Mackenzie and Natalie Stoljar (eds), *Relational Autonomy: Feminist Perspectives on Autonomy, Agency and the Social Self* (OUP 2000) 3-31.

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