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THE RIGHT TO DIE WITH DIGNITY: EXAMINING BODILY AUTONOMY, THE RIGHT TO PRIVACY AND THE CONSTITUTIONAL VALIDITY OF PASSIVE EUTHANASIA IN POST-PUTTASWAMY INDIA

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ABSTRACT

The constitutional right to life under Article 21 of the Constitution of India, 1950 has been interpreted by the Supreme Court to encompass a life lived with dignity, meaning, and personal autonomy. The question of whether this guarantee extends to the manner of one's death, specifically through the withdrawal of life-sustaining medical treatment, has occupied the Indian judiciary for several decades and has acquired renewed constitutional force following the nine-judge Constitution Bench's landmark ruling in Justice K.S. Puttaswamy (Retd.) v. Union of India (2017), which unanimously recognised the right to privacy as a fundamental right under Part III of the Constitution. The five-judge Constitution Bench's ruling in Common Cause v. Union of India (2018) constitutes the most authoritative judicial articulation of the right to die with dignity in Indian law, validating passive euthanasia and advance medical directives as exercises of the fundamental rights to life, privacy, and bodily autonomy. This paper undertakes a comprehensive evaluation of the constitutional foundations, philosophical underpinnings, and practical limitations of this framework. It examines the doctrinal evolution from P. Rathinam to Gian Kaur to Common Cause, analyses the privacy jurisprudence of Puttaswamy and its implications for end-of-life decision-making, and engages with comparative constitutional frameworks from the United Kingdom, Canada, and the United States. The paper argues that while the Common Cause framework represents a significant constitutional advance, it falls short in several respects: the advance directive regime is procedurally burdensome, Parliament has not enacted the requisite implementing legislation,

and the active-passive euthanasia distinction merits critical re-examination. The paper concludes by identifying the institutional and legislative reforms needed to give substantive content to the right to die with dignity in post-Puttaswamy India.

Keywords: Passive Euthanasia; Right to Privacy; Bodily Autonomy; Advance Medical Directives; Transformative Constitutionalism

I. INTRODUCTION

The constitutional right to life, guaranteed under Article 21 of the Constitution of India, 1950, has been interpreted expansively by the Supreme Court to encompass not merely the animal existence of the body, but a life lived with dignity, meaning, and personal autonomy. The question of whether this constitutional guarantee extends to the manner and timing of one's death, specifically through the withdrawal of life-sustaining medical treatment, has occupied the Indian judiciary for several decades and has acquired renewed constitutional force in the wake of the nine-judge Constitution Bench's landmark ruling in Justice K.S. Puttaswamy (Retd.) v. Union of India (2017).[1] The unanimous recognition of the right to privacy as a fundamental right guaranteed under Part III of the Constitution has fundamentally reoriented the jurisprudential landscape within which questions of bodily autonomy and end of life decision making must now be adjudicated.

The five-judge Constitution Bench's ruling in Common Cause v. Union of India (2018)[2] constitutes the most authoritative judicial articulation of the constitutional right to die with dignity in Indian law. The Bench held that passive euthanasia, defined as the withdrawal or withholding of life-sustaining medical treatment from a patient who is either in a permanent vegetative state or terminally ill, is constitutionally valid as an exercise of the fundamental right to life and personal liberty under Article 21. The Court further recognised the legal validity of advance medical directives, through which a competent adult may record consent for the withdrawal of life support in the event of future incapacity. These holdings, read alongside the transformative privacy jurisprudence of Puttaswamy, represent a constitutional milestone in the recognition of bodily autonomy and personal sovereignty as core constitutional values.

This research paper undertakes a comprehensive examination of the constitutional validity and doctrinal foundations of passive euthanasia in post-Puttaswamy India. Part II traces the

[1]Justice K.S. Puttaswamy (Retd.) v. Union of India, (2017) 10 SCC 1 (India).

[2]Common Cause v. Union of India, (2018) 5 SCC 1 (India).

historical and doctrinal evolution of the right to die in Indian constitutional jurisprudence. Part III analyses the content and scope of the right to privacy as articulated in Puttaswamy and its implications for bodily autonomy and end of life decision making. Part IV examines the Common Cause judgment in detail, including its treatment of passive euthanasia and advance directives and the safeguards prescribed by the Court. Part V engages with the philosophical and ethical foundations of the right to die with dignity, drawing on liberal theory and comparative constitutional frameworks. Part VI critically evaluates the limitations and outstanding challenges in the post-Common Cause framework. Part VII offers concluding observations.

II. HISTORICAL AND DOCTRINAL EVOLUTION OF THE RIGHT TO DIE IN INDIAN JURISPRUDENCE

A. THE EARLY POSITION: LIFE AS AN ABSOLUTE AND NON-WAIVABLE RIGHT

The Supreme Court's earliest engagements with the question of whether the right to life under Article 21 encompasses a right to die were characterised by judicial conservatism and a textual literalism that treated life as an absolute and non-waivable constitutional entitlement. In P. Rathinam v. Union of India (1994),[3] a two-judge Bench held, in the context of the constitutional validity of Section 309 of the Indian Penal Code, 1860, which criminalised attempted suicide, that Article 21's guarantee of the right to life included within its ambit the right not to live, or the right to die. The Court reasoned that if one possesses a right, the corollary of not exercising that right must equally be available. This reading, while broadly welcoming of personal autonomy, was almost immediately overruled by a Constitution Bench of five judges in Gian Kaur v. State of Punjab (1996).[4]

In Gian Kaur, the Constitution Bench emphatically held that Article 21,[5] which guarantees the right to life and personal liberty, cannot be construed to include within it a right to die. The Court reasoned that the sanctity of life is a foundational constitutional value and that the right to life does not comprehend a right to extinguish it. The Bench distinguished between the right to live with dignity, which it affirmed as constitutional, and the right to die, which it held to be

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

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

[5]INDIA CONST. art. 21.

outside the scope of Article 21. Crucially, however, the Court at paragraphs 24 and 25 of the judgment did not expressly foreclose the possibility that the withdrawal of life-sustaining treatment from a terminally ill or permanently vegetative patient might be treated differently from active steps to end life, thereby leaving a doctrinal aperture through which the subsequent jurisprudence would develop. Common Cause itself, when constituted treated certain observations in Gian Kaur as requiring reconsideration to the extent they could be read as impliedly prohibiting passive euthanasia.

B. THE ARUNA SHANBAUG JUDGMENT: PASSIVE EUTHANASIA RECOGNISED BY JUDICIAL DIRECTION

The most significant pre-Common Cause articulation of the law on passive euthanasia is found in Aruna Ramchandra Shanbaug v. Union of India (2011),[6] in which a two-judge Bench of the Supreme Court, speaking through Justice Markandey Katju, recognised passive euthanasia as constitutionally permissible in India in the absence of specific legislation and vested in the High Courts under Article 226 of the Constitution the parens patriae jurisdiction to authorise the withdrawal of life-sustaining treatment in appropriate cases.[7] The judgment was rendered in the context of a writ petition filed on behalf of Aruna Shanbaug, a nurse at King Edward Memorial Hospital, Mumbai, who had been in a permanent vegetative state for over three decades following a brutal assault in 1973. The Court refused permission to withdraw the nasogastric tube through which Aruna was fed, holding that the hospital staff who had cared for her objected to the withdrawal and that their wishes were entitled to weight under the parens patriae doctrine. However, the Court laid down detailed guidelines for the exercise of parens patriae jurisdiction by High Courts in future cases involving passive euthanasia.

The Aruna Shanbaug judgment, while a significant step forward, was criticised on several grounds. First, it failed to clearly ground the right to die with dignity in Article 21 or in any identifiable fundamental right, relying instead on the common law doctrine of best interests and the parens patriae jurisdiction of superior courts. Second, it did not recognise the legal validity of advance medical directives executed by competent adults, leaving the law on living wills uncertain. Third, the procedural framework it prescribed, requiring High Court approval in every case of withdrawal of treatment, was considered unduly cumbersome and likely to

[6]Aruna Ramchandra Shanbaug v. Union of India, (2011) 4 SCC 454 (India).

[7]Aruna Ramchandra Shanbaug v. Union of India, (2011) 4 SCC 454, at para. 87 (exercising parens patriae jurisdiction and laying down guidelines for High Courts in passive euthanasia cases).

impede the exercise of the right in practice. These limitations were comprehensively addressed by the Constitution Bench in Common Cause.

III. THE PUTTASWAMY REVOLUTION: PRIVACY, BODILY AUTONOMY, AND THE DIGNITY TRIAD

A. THE UNANIMOUS RECOGNITION OF PRIVACY AS A FUNDAMENTAL RIGHT

The nine-judge Constitution Bench's ruling in Justice K.S. Puttaswamy (Retd.) v. Union of India (2017)[8] stands as the most transformative constitutional judgment of the post-liberalisation era. The Bench unanimously overruled the earlier decisions in M.P. Sharma v. Satish Chandra (1954) and Kharak Singh v. State of Uttar Pradesh (1963), which had denied the status of a fundamental right to privacy, and held that the right to privacy is an intrinsic component of the fundamental rights guaranteed by Part III of the Constitution, including Articles 14, 19, and 21. All six concurring opinions converged on the proposition that privacy is a natural right inhering in every individual by virtue of their humanity and dignity and is not a gift of the State or the Constitution.

Justice D.Y. Chandrachud's concurring opinion in Puttaswamy, which has come to be regarded as the most doctrinally comprehensive articulation of the right to privacy, identified three core dimensions of privacy: informational privacy, the right to control the dissemination of personal information; decisional autonomy, the right to make choices about matters intimate to one's life; and bodily integrity, the right to sovereignty over one's own body.[9] It is the second and third of these dimensions, namely decisional autonomy and bodily integrity, that are most directly implicated in the context of end of life decision making and passive euthanasia.

B. BODILY AUTONOMY AS A CONSTITUTIONAL IMPERATIVE

The recognition of bodily integrity as a dimension of the fundamental right to privacy in Puttaswamy has profound implications for the constitutional analysis of passive euthanasia. If the individual possesses a constitutionally protected interest in sovereignty over their own body, it follows that a competent adult has the right to refuse medical treatment, including life-sustaining treatment, and that this refusal cannot be overridden by the State or by medical

[8]Justice K.S. Puttaswamy (Retd.) v. Union of India, (2017) 10 SCC 1 (India). See supra note 1.

[9]Justice K.S. Puttaswamy (Retd.) v. Union of India, (2017) 10 SCC 1, at para. 325 (Chandrachud, J., concurring) (identifying informational privacy, decisional autonomy, and bodily integrity as the three core dimensions of the constitutional right to privacy).

professionals without constitutional justification. This principle received its most explicit constitutional endorsement in Indian law through Puttaswamy and was directly applied to the euthanasia context in Common Cause. The constitutional framework for bodily autonomy in India is further reinforced by the Court's interpretation of Article 21 in the post-Maneka Gandhi era.[10] The Court's holding in Maneka Gandhi v. Union of India (1978) transformed Article 21 from a procedural guarantee into a substantive fundamental right, enabling the Court to progressively expand the right to life to encompass the right to live with human dignity,[11] the right to livelihood,[12] and ultimately the right to die with dignity.[13]

C. DIGNITY AS THE CONSTITUTIONAL ANCHOR

The concept of human dignity occupies a foundational position in the constitutional jurisprudence of both Puttaswamy and Common Cause. All six opinions in Puttaswamy treat dignity as the ultimate normative anchor of the fundamental rights guaranteed by Part III, drawing on the Preamble's commitment to securing to all citizens the dignity of the individual. In the euthanasia context, dignity performs a dual and sometimes paradoxical function. On one hand, the sanctity of human life is itself a dimension of dignity, suggesting a duty to preserve life. On the other hand, the dignity of the dying individual, including the right to be free from prolonged and pointless suffering and to exercise control over the manner of their death, equally engages constitutional dignity values. The Common Cause Bench resolved this tension by holding that dignity in dying is as constitutionally significant as dignity in living and that a State that compels a terminally ill patient to continue receiving unwanted life-sustaining treatment violates that patient's constitutional dignity.

IV. COMMON CAUSE V. UNION OF INDIA: CONSTITUTIONAL VALIDITY AND INSTITUTIONAL FRAMEWORK

A. THE FIVE-JUDGE BENCH AND THE ISSUES BEFORE THE COURT

[10]Maneka Gandhi v. Union of India, (1978) 1 SCC 248 (India) (holding that the procedure established by law under Article 21 must be fair, just, and reasonable and must satisfy Articles 14 and 19, thereby converting Article 21 into a substantive fundamental right).

[11]Francis Coralie Mullin v. Administrator, Union Territory of Delhi, (1981) 1 SCC 608, at para. 8 (holding that Article 21 includes the right to live with basic human dignity).

[12]Olga Tellis v. Bombay Municipal Corporation, (1985) 3 SCC 545 (India) (holding that the right to livelihood is a component of the right to life under Article 21).

[13]Common Cause v. Union of India, (2018) 5 SCC 1, at para. 133 (Misra, C.J., and Khanwilkar, J.) (holding that the right to die with dignity is an inextricable part of the right to live with dignity under Article 21).

The Constitution Bench in Common Cause v. Union of India (2018)[14] was constituted to resolve definitively the questions that Aruna Shanbaug had left open: whether passive euthanasia is constitutionally valid, whether advance medical directives have legal recognition, and if so, what procedural framework should govern their execution and implementation. The Bench comprised Chief Justice Dipak Misra and Justices A.K. Khanwilkar, D.Y. Chandrachud, A.M. Sapre, and A.K. Sikri. Four separate but concurring judgments were delivered, all arriving at the same substantive conclusions while varying in their emphasis and doctrinal reasoning.

B. PASSIVE EUTHANASIA AS A CONSTITUTIONAL RIGHT

The Bench unanimously held that a terminally ill patient or a patient in a permanent vegetative state has the constitutional right under Article 21 to the withdrawal of life-sustaining medical treatment and that the exercise of this right does not attract criminal liability under Sections 306 or 309 of the Indian Penal Code, 1860.[15] The Court distinguished passive euthanasia, which involves the withholding or withdrawal of treatment that allows the disease process to take its natural course, from active euthanasia, which involves the administration of a lethal substance to cause death. While passive euthanasia was held to be constitutionally valid, active euthanasia was held to fall outside the scope of the right to die with dignity as currently recognised by Indian constitutional law, consistent with the approach taken in comparative jurisdictions such as England and Wales.[16]

Justice Chandrachud's concurring opinion provides the most analytically rigorous constitutional basis for the holding. Drawing directly on the bodily integrity and decisional autonomy dimensions of privacy affirmed in Puttaswamy, he held that a competent adult's informed refusal of medical treatment, including life-sustaining treatment, is an exercise of the fundamental right to privacy under Article 21 and cannot be overridden by the State or any

[14]Common Cause v. Union of India, (2018) 5 SCC 1 (India). The Bench comprised Chief Justice Dipak Misra and Justices A.K. Khanwilkar, D.Y. Chandrachud, A.M. Sapre, and A.K. Sikri. Four separate but concurring judgments were delivered.

[15]Common Cause v. Union of India, (2018) 5 SCC 1, at paras. 189 to 191 (holding that the exercise of the right to die with dignity by refusing life-sustaining treatment does not attract criminal liability under Sections 306 or 309 of the Indian Penal Code, 1860).

[16]Airedale NHS Trust v. Bland, [1993] AC 789 (HL) (Eng.) (holding that the withdrawal of artificial nutrition and hydration from a patient in a permanent vegetative state is lawful as being in the patient's best interests, and drawing the foundational acts-omissions distinction in end-of-life care).

other party.[17] The right to refuse treatment does not require the patient to be terminally ill; any competent adult may refuse any form of medical treatment. In the passive euthanasia context, however, the most significant cases arise where the patient is no longer competent to express their wishes and where the decision must be made on the basis of either a previously executed advance directive or by a surrogate decision maker guided by the best interests standard.

C. THE LEGAL STATUS OF ADVANCE MEDICAL DIRECTIVES

One of the most significant holdings in Common Cause is the recognition of the legal validity of advance medical directives under Indian law.[18] The Court held that a competent adult may execute an advance directive specifying the medical treatment they consent to or refuse in the event that they become incapacitated and unable to communicate their wishes. Such a directive, if executed in accordance with the procedural requirements prescribed by the Court, shall be binding on the medical practitioners and the family of the patient, subject to review by a medical board.

The Court prescribed detailed procedural requirements for the execution of a valid advance directive.[19] The directive must be in writing, signed by the executor in the presence of two witnesses, countersigned by a Judicial Magistrate of the First Class, preserved by the Magistrate and the competent officer of the local government, and a copy furnished to the family physician. These requirements, while designed to prevent abuse and ensure the authenticity and voluntariness of the directive, have been criticised as being unduly onerous and likely to act as a practical barrier to the exercise of the right for a large section of the population, particularly those without easy access to Magistrates and other public officials.

D. SAFEGUARDS, PROCEDURE, AND THE ROLE OF MEDICAL BOARDS

Recognising the potential for abuse and the need to protect vulnerable patients and medical professionals, the Court in Common Cause prescribed a detailed two-tier Medical Board framework for cases where passive euthanasia is sought either pursuant to an advance directive

[17]Common Cause v. Union of India, (2018) 5 SCC 1, at paras. 196 to 198 (Chandrachud, J., concurring) (holding that a competent adult's informed refusal of medical treatment, grounded in the right to bodily integrity and decisional autonomy under Article 21, cannot be overridden by the State or any other party).

[18]Common Cause v. Union of India, (2018) 5 SCC 1, at paras. 185 to 192 (recognising the legal validity of advance medical directives and holding that a competent adult may execute a binding advance directive specifying treatment to be withheld or withdrawn in the event of future incapacity).

[19]Common Cause v. Union of India, (2018) 5 SCC 1, at para. 270 (prescribing the detailed procedural requirements for execution of a valid advance directive, including signature before two witnesses and countersignature by a Judicial Magistrate of the First Class).

or in its absence.[20] Where an advance directive exists, the physician treating the patient must first consult a Hospital Medical Board comprising a minimum of three specialists and thereafter seek the approval of a Medical Board constituted by the Chief Medical Officer of the District. Where there is no advance directive, the same Medical Board process applies, with the family or next of kin performing the role of surrogate decision maker on the basis of the patient's best interests.

The Court further held that any decision of the Medical Board authorising the withdrawal of treatment may be challenged before the High Court by any aggrieved party, including family members and medical professionals with conscientious objections.[21] While this mechanism preserves judicial oversight, it also introduces a significant element of delay and uncertainty into a process that frequently requires urgent decision making in a clinical setting. The Law Commission of India, in its Report No. 241 on Passive Euthanasia (2012), had recommended a less court-centric framework precisely because of the practical difficulties that judicial intervention creates in end of life care.[22]

V. PHILOSOPHICAL AND ETHICAL FOUNDATIONS OF THE RIGHT TO DIE WITH DIGNITY

A. LIBERAL THEORY AND THE HARM PRINCIPLE

The philosophical underpinning of the right to die with dignity finds its most powerful expression in the liberal tradition of political philosophy. John Stuart Mill's harm principle, articulated in On Liberty (1859), holds that the only legitimate purpose for which power can be rightfully exercised over any member of a civilised community against their will is to prevent harm to others; the individual's own good, whether physical or moral, is not a sufficient warrant.[23] Applied to the euthanasia context, the harm principle suggests that the State has no legitimate interest in compelling a dying individual to continue receiving unwanted medical

[20]Common Cause v. Union of India, (2018) 5 SCC 1, at paras. 203 to 214 (prescribing the two-tier Medical Board framework: a Hospital Medical Board of at least three specialists to be consulted first, followed by a Medical Board constituted by the District Chief Medical Officer, whose approval is required before life-sustaining treatment may be withdrawn).

[21]Common Cause v. Union of India, (2018) 5 SCC 1, at paras. 215 to 216 (providing that any decision of the Medical Board authorising withdrawal of treatment may be challenged before the High Court by any aggrieved party).

[22]Law Commission of India, Report No. 241: Passive Euthanasia: A Relook (2012) (recommending a less court-centric framework on the ground that mandatory judicial approval in every case of withdrawal of treatment creates unacceptable delays in end of life care).

[23]John Stuart Mill, On Liberty 13 (Elizabeth Rapaport ed., Hackett Publishing 1978) (1859).

treatment, because the refusal of such treatment harms no person other than the patient, who consents to and indeed desires the outcome. Kant's moral philosophy, while traditionally associated with duties rather than rights, provides a complementary foundation through the concept of rational autonomy.[24] The Kantian imperative to treat every rational being as an end in themselves and never merely as a means entails that a dying patient must be treated as a rational agent capable of making informed decisions about their own body and medical treatment. The State or medical profession's imposition of unwanted treatment instrumentalises the patient in a manner incompatible with the respect for dignity and rational agency that morality demands.

Ronald Dworkin's account of the right to die, developed in Life's Dominion (1993), is particularly illuminating in the Indian constitutional context.[25] Dworkin distinguishes between experiential interests, those interests one has in having pleasurable experiences, and critical interests, those interests one has in living a life that reflects one's deepest values and commitments. He argues that when an individual's experiential interests are exhausted by irreversible terminal illness or permanent vegetative state, the critical interest in dying in a manner consistent with one's values and dignity ought to prevail. Justice Chandrachud's opinion in Common Cause reflects a similar normative structure, treating the individual's interest in dying with dignity as a critical interest deserving constitutional protection.

B. COMPARATIVE CONSTITUTIONAL PERSPECTIVES

The constitutional validity of passive euthanasia has been recognised across a range of comparative constitutional systems. The House of Lords in Airedale NHS Trust v. Bland (1993),[26] which has been consistently cited by the Indian Supreme Court, held that the withdrawal of artificial nutrition and hydration from a patient in a permanent vegetative state is lawful as being in the patient's best interests and does not constitute murder or any other criminal offence. The acts-omissions distinction drawn in Bland, characterising the withdrawal

[24]Immanuel Kant, Groundwork of the Metaphysics of Morals 41 (Mary Gregor trans., Cambridge Univ. Press 1998) (1785).

[25]Ronald Dworkin, Life's Dominion: An Argument About Abortion, Euthanasia, and Individual Freedom 217 (1993).

[26]Airedale NHS Trust v. Bland, [1993] AC 789 (HL) (Eng.) (holding that the withdrawal of artificial nutrition and hydration from a patient in a permanent vegetative state is lawful as being in the patient's best interests, and drawing the foundational acts-omissions distinction in end-of-life care).

of treatment as an omission rather than an act, has been foundational in the Indian jurisprudence.

The Supreme Court of Canada's ruling in Carter v. Canada (Attorney General) (2015)[27] went further than the Indian position, striking down the criminal prohibition on physician-assisted dying as unconstitutional in cases where the patient is a competent adult with a grievous and irremediable medical condition causing enduring suffering. The Canadian Court grounded this holding in the right to life, liberty, and security of the person under Section 7 of the Canadian Charter of Rights and Freedoms, reasoning that the prohibition forced individuals to take their own lives prematurely while still physically capable of doing so, thereby paradoxically curtailing rather than protecting the right to life.

The United States Supreme Court's decisions in Cruzan v. Director, Missouri Department of Health (1990)[28] and Washington v. Glucksberg (1997)[29] established that, while the constitutional right of a competent adult to refuse life-sustaining medical treatment is clearly protected, the right to physician-assisted suicide is not a fundamental right under the Due Process Clause of the Fourteenth Amendment.[30] The distinction drawn by the US Supreme Court between the refusal of treatment and the seeking of assisted dying closely mirrors the position adopted by the Indian Supreme Court in Common Cause, which validated passive euthanasia and advance directives while declining to address the question of active euthanasia.

C. THE MEDICAL ETHICS DIMENSION

Medical ethics has historically been the arena in which the tensions between the duty to preserve life, the duty to relieve suffering, and the duty to respect patient autonomy are most acutely felt. The doctrine of informed consent, foundational to modern medical ethics and recognised in the World Medical Association's Declaration on the Rights of the Patient,[31]

[27]Carter v. Canada (Attorney General), [2015] 1 SCR 331 (Can.) (striking down the criminal prohibition on physician-assisted dying as unconstitutional under Section 7 of the Canadian Charter of Rights and Freedoms where the patient is a competent adult suffering a grievous and irremediable medical condition).

[28]Cruzan v. Director, Missouri Department of Health, 497 U.S. 261 (1990) (holding that a competent adult has a constitutionally protected liberty interest in refusing unwanted medical treatment, including life-sustaining treatment).

[29]Washington v. Glucksberg, 521 U.S. 702 (1997) (holding that the right to physician-assisted suicide is not a fundamental right under the Due Process Clause of the Fourteenth Amendment).

[30]Vacco v. Quill, 521 U.S. 793 (1997) (affirming the constitutional validity of the distinction between withdrawal of life-sustaining treatment and physician-assisted suicide).

[31]World Medical Association Declaration on the Rights of the Patient (amended 2005), Principle 10 (affirming the patient's right to refuse treatment after being fully informed of the consequences).

establishes that competent adults have the right to refuse any medical treatment after receiving adequate information about its nature, risks, and alternatives. The application of informed consent to the withdrawal of life-sustaining treatment is logically straightforward, though its implementation in clinical practice is frequently complicated by family dynamics, institutional pressures, and the ethical commitments of individual practitioners.

The principle of double effect, which holds that an action with both a good and a harmful effect is morally permissible if the harmful effect is not intended but only foreseen, provides the ethical basis for the medical practice of palliative sedation, in which the relief of terminal suffering through opioids may incidentally hasten death. The Supreme Court in Common Cause did not directly address the double effect doctrine, but its endorsement of palliative care as an aspect of the right to die with dignity implicitly legitimises medical practices that are consistent with this principle.

VI. LIMITATIONS AND OUTSTANDING CHALLENGES IN THE POST-COMMON CAUSE FRAMEWORK

A. THE PROCEDURAL BURDEN AND ACCESS TO JUSTICE

The most immediately significant limitation of the Common Cause framework is the complexity and procedural burden of the advance directive regime. The requirement that an advance directive be countersigned by a Judicial Magistrate of the First Class is, in practical terms, an obstacle that will prevent a large proportion of Indian citizens from executing valid advance directives. India's Magistracy is overburdened, courts are frequently distant from rural areas, and the formality of the process is likely to be alien and intimidating to citizens without legal literacy. The consequence is that the right recognised by the Court will in practice be accessible primarily to the educated urban middle class, raising serious concerns about equality and the universality of constitutional rights under Article 14.[32]

The Supreme Court itself appears to have recognised this concern, directing the Union and State Governments to take steps to simplify the procedure and to make information about advance directives widely available.[33] However, in the absence of specific legislation, the cumbersome Magistrate countersignature requirement remains in force. The Government's

[32]INDIA CONST. art. 14 (guaranteeing equality before the law and equal protection of the laws to all persons).

[33]Common Cause v. Union of India, (2018) 5 SCC 1, at para. 285 (directing the Union and State Governments to give wide publicity to the judgment and to implement the advance directive framework through appropriate legislation).

failure to enact the Medical Treatment of Terminally Ill Patients (Protection of Patients and Medical Practitioners) Bill, 2016,[34] which would have provided a statutory framework for passive euthanasia and advance directives, reflects the deep political and social sensitivities surrounding end of life legislation in India.

B. THE ABSENCE OF LEGISLATION AND REGULATORY LACUNAE

The continued absence of comprehensive legislation on passive euthanasia and advance directives more than six years after the Common Cause judgment represents a significant gap in the constitutional rights framework. The Court, in its capacity as a quasi-legislative actor, has done what it can through detailed judicial guidelines, but these cannot substitute for a statutory framework enacted by Parliament that addresses the full range of clinical, ethical, and procedural questions that arise in end of life care. In particular, the rights of patients in psychiatric institutions, the treatment of minors and persons with intellectual disabilities in end of life situations, the obligations of hospitals and medical professionals with conscientious objections, and the liability regime for practitioners who act in good faith on an advance directive remain inadequately addressed by the existing judicial framework.

C. THE ACTIVE-PASSIVE DISTINCTION AND THE QUESTION OF ACTIVE EUTHANASIA

The constitutional framework established by Common Cause draws a clear line between passive euthanasia, which is constitutionally valid, and active euthanasia, which is not. This distinction, while doctrinally well established in comparative law,[35] has been challenged by bioethicists and philosophers who argue that it lacks moral coherence. If the basis of the right to die with dignity is the patient's autonomous choice and their interest in being free from suffering, it is not clear why the method of achieving death, whether through withdrawal of treatment or through the administration of a lethal substance, should be constitutionally determinative. The Canadian Supreme Court's decision in Carter, which validated physician-assisted dying as a constitutional right, illustrates that the active-passive distinction is not a universal constitutional boundary. The question of whether India's constitutional jurisprudence

[34]Medical Treatment of Terminally Ill Patients (Protection of Patients and Medical Practitioners) Bill, 2016 (India) (lapsed; not enacted as of the date of this paper).

[35]See Airedale NHS Trust v. Bland, [1993] AC 789 (HL) (Eng.), supra note 16; Vacco v. Quill, 521 U.S. 793 (1997), supra note 30 (both affirming the constitutional and legal significance of the acts-omissions distinction in end-of-life care).

will eventually move in the same direction is likely to be the defining issue in the next generation of euthanasia litigation before the Supreme Court.

D. CONSTITUTIONAL MORALITY, SOCIAL MORALITY, AND PUBLIC OPINION

The recognition of passive euthanasia as a constitutional right places the Court in a position of some tension with prevailing social and religious attitudes toward death and dying in India. Across the major religious traditions represented in India, including Hinduism, Islam, and Christianity, there exist strong cultural and theological currents that resist the characterisation of death as a matter of individual autonomous choice. These cultural attitudes shape the views of patients, families, and medical professionals and may create practical resistance to the implementation of the Common Cause framework even where the legal entitlement is formally recognised.

The Supreme Court's jurisprudence on constitutional morality, developed most prominently in Navtej Singh Johar v. Union of India (2018),[36] holds that constitutional morality, grounded in the fundamental rights and values of the Constitution, must prevail over popular or social morality when the two conflict. Applied to the euthanasia context, this means that the State's interest in giving expression to social or religious opposition to euthanasia cannot justify the denial of the constitutional right to die with dignity to a terminally ill patient who chooses to exercise that right.

VII. CONCLUSION

The post-Puttaswamy constitutional framework for the right to die with dignity represents one of the most significant advances in Indian fundamental rights jurisprudence of the past decade. The recognition of privacy as a fundamental right in Puttaswamy provided the constitutional foundations on which the Common Cause Bench erected a carefully reasoned and doctrinally coherent framework for passive euthanasia and advance medical directives. The holdings of the Court are consistent with the best comparative constitutional thinking on the subject and are grounded in a philosophically defensible conception of dignity, autonomy, and the right to live and die on one's own terms.

[36]Navtej Singh Johar v. Union of India, (2018) 10 SCC 1, at para. 456 (Chandrachud, J., concurring) (holding that constitutional morality, grounded in fundamental rights, must prevail over popular or social morality when the two conflict).

Yet the translation of these constitutional holdings into a lived reality for dying patients remains a project that is far from complete. The procedural complexity of the advance directive regime, the absence of comprehensive legislation, the unresolved questions around active euthanasia, and the practical and cultural barriers to the exercise of the right in clinical settings continue to impede the full realisation of the constitutional right to die with dignity. The responsibility for bridging the gap between constitutional declaration and practical reality lies, in the first instance, with Parliament, which must enact the legislation that the Court's judgment demands. It lies also with the medical profession, which must integrate the new constitutional framework into clinical practice and training. And it lies ultimately with civil society, which must foster the informed public deliberation about death and dying that a constitutional democracy requires.

The right to die with dignity is not a nihilistic affirmation of death over life, but a humanistic insistence that the final chapter of a human life must be written, as far as possible, by the person who has lived it. That insistence, grounded in the deepest values of constitutional dignity and personal autonomy, deserves to be honoured not merely in the text of judicial judgments but in the fabric of law, medicine, and social practice in India.