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WHEN AUTONOMY ENDS : SURROGATE DECISION - MAKING AND THE WITHDRAWAL OF LIFE - SUSTAINING TREATMENT IN INDIA

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ABSTRACT : The withdrawal of life-sustaining treatment presents a complex intersection of medical ethics, constitutional law and individual autonomy. In India, the problem becomes particularly significant when a patient loses decision-making capacity and can no longer communicate a preference regarding continued medical treatment. In such circumstances, surrogate decision-making assumes a central role, raising questions concerning who should decide, which standards should govern the decision, and how the patient's autonomy and dignity can be preserved. This paper examines the legal and ethical foundations of surrogate decision-making in India, with particular emphasis on the substituted judgment and best-interests standards. It traces the development of Indian jurisprudence from Aruna Ramachandra Shanbaug v. Union of India to Common Cause v. Union of India and subsequent procedural developments concerning advance medical directives and Medical Boards. The paper further analyses the respective roles of patients, surrogates, medical professionals and institutional bodies in decisions concerning the withholding or withdrawal of life-sustaining treatment. It identifies practical challenges including limited awareness of advance directives, unequal healthcare infrastructure, medical uncertainty, family influence and inadequate access to palliative care. Through a comparative examination of selected foreign frameworks, the paper argues for a patient-centred approach that protects autonomy without disregarding medical realities and safeguards vulnerable patients from arbitrary decision-making. It concludes by proposing greater awareness of advance-care planning, clearer institutional protocols, professional training and strengthened palliative-care systems to ensure that end-of-life decisions remain lawful, transparent and consistent with patient dignity and welfare.

Keywords : Patient Autonomy; Surrogate Decision-Making; Life-Sustaining Treatment; Advance Medical Directives; End-of-Life Care; Right to Die with Dignity; Best Interests; Substituted Judgment; Medical Boards; Palliative Care.

1. INTRODUCTION

Modern medical technology has significantly altered the circumstances in which death occurs. Advances in intensive care, mechanical ventilation, artificial nutrition and hydration, and other forms of life-sustaining treatment can preserve physiological functions even when recovery from an underlying illness or injury may no longer be medically achievable. In such circumstances, the question of whether treatment should be continued is no longer exclusively a medical determination; it increasingly involves questions of individual autonomy, dignity, informed consent, family participation, professional responsibility, and constitutional rights. The difficulty becomes particularly acute where a patient is unable to communicate or make an informed decision concerning further medical treatment.

Patient autonomy occupies a central position in contemporary medical decision-making. It recognises an individual's authority to make decisions concerning their own body and medical treatment, including, subject to applicable legal limitations, the right to refuse treatment. In India, this principle has acquired constitutional significance through the interpretation of the right to life and personal liberty under Article 21 of the Constitution. The Supreme Court's jurisprudence has progressively connected Article 21 with human dignity and the individual's interest in determining the manner in which medical treatment is accepted or refused.

The exercise of autonomy, however, becomes problematic when a patient loses decision-making capacity. A person may be unconscious, permanently unconscious, suffering from an irreversible neurological condition, or otherwise incapable of communicating a legally meaningful treatment preference. At this point, decision-making may shift towards an advance medical directive, where one exists, or towards a surrogate acting on behalf of the patient. This creates a fundamental legal question: when the patient's own voice is unavailable, whose judgment should determine whether life-sustaining treatment ought to be continued or withdrawn?

The Indian Supreme Court first confronted these questions in Aruna Ramachandra Shanbaug v. Union of India, where it recognised a limited legal framework for the withdrawal of life support

in cases involving a patient lacking decision-making capacity. The constitutional position was subsequently transformed by the Constitution Bench decision in Common Cause (A Registered Society) v. Union of India, which recognised the right to die with dignity as part of Article 21 and affirmed the legal significance of advance medical directives and the refusal or withdrawal of life-sustaining treatment under prescribed safeguards. The Court modified the procedural framework in 2023 to make the mechanism more workable. More recently, the Supreme Court's 2026 decision in Harish Rana v. Union of India addressed the withdrawal of clinically assisted nutrition and hydration and reiterated that decisions concerning an incapacitated patient must be guided by the patient's best interests, while emphasising the importance of palliative and end-of-life care.

Against this background, the present study examines the legal position governing surrogate decision-making and withdrawal of life-sustaining treatment in India. It particularly analyses the relationship between patient autonomy and surrogate authority, the distinction between substituted judgment and the best-interests standard, the role of advance medical directives and medical boards, and the constitutional basis of end-of-life decision-making. The study further evaluates whether the existing judicial framework adequately protects patient autonomy while preventing arbitrary or uninformed decisions by relatives, medical professionals, or other decision-makers.

2. CONCEPTUAL FRAMEWORK: PATIENT AUTONOMY, DECISION-MAKING CAPACITY AND LIFE-SUSTAINING TREATMENT

2.1 Patient Autonomy

Patient autonomy is one of the foundational principles governing contemporary medical decision-making. It recognises the individual as an active decision-maker in matters concerning his or her own body, health and medical treatment, rather than merely as the recipient of professional medical judgment. In the context of end-of-life care, autonomy assumes particular importance because medical treatment may preserve physiological life even when the underlying disease is irreversible or the prospect of meaningful recovery is negligible. The ethical significance of autonomy therefore lies not merely in permitting a patient to choose a particular

treatment, but also in recognising the patient's authority to decline an intervention that he or she does not wish to undergo.

The principle is closely connected with the doctrine of informed consent. A valid medical decision ordinarily requires that the patient possess sufficient information regarding the nature, risks, benefits and alternatives of the proposed intervention and possess the capacity to make a voluntary choice. Autonomy consequently requires more than the formal recording of consent; it requires respect for the patient's ability to determine the objectives of medical care in accordance with his or her own values and preferences. Beauchamp and Childress place autonomy within the four-principle framework of biomedical ethics, alongside beneficence, non-maleficence and justice, while emphasising that respect for autonomy requires recognition of an individual's capacity for self-determination.

In end-of-life situations, however, autonomy encounters an important limitation: the patient may cease to possess the capacity necessary to exercise it. A patient suffering from severe neurological injury, advanced cognitive impairment, prolonged unconsciousness or another condition affecting decisional capacity may be unable to understand relevant medical information, appreciate the consequences of available choices or communicate a voluntary decision. The disappearance of decisional capacity does not necessarily mean that the patient's previously expressed preferences cease to have ethical or legal significance. Rather, it creates the difficult question of how those preferences should continue to guide medical decision-making.

The Indian Council of Medical Research (“ICMR”) has recognised autonomy, decision-making capacity, best interests, advance directives and surrogate decision-making as distinct but interconnected concepts within end-of-life care. Its terminology framework defines decision-making capacity in relation to the patient's ability to make healthcare decisions and identifies a surrogate as a person who may participate in decision-making when the patient lacks such capacity. This distinction is important because incapacity is a limitation on the patient's present ability to decide; it is not necessarily a rejection of the patient's underlying values or previously expressed wishes.

Indian constitutional jurisprudence provides an additional dimension to this principle. The recognition of decisional autonomy as part of personal liberty under Article 21 strengthens the argument that medical decision-making should ordinarily begin with the preferences of the individual rather than with the interests of the State, family or medical institution. At the same time, autonomy cannot operate in isolation. End-of-life decisions involve competing considerations of beneficence, non-maleficence, dignity and the professional obligations of healthcare providers.

Thus, autonomy in end-of-life care should not be understood simply as an unrestricted right of the patient to demand or refuse every conceivable medical intervention. Rather, it represents a presumption in favour of respecting the competent patient's informed choices, subject to the legal and clinical framework governing particular interventions. Where competence is lost, the central challenge becomes determining how that autonomy can be preserved through advance directives or, where necessary, surrogate decision-making.

2.2 Decision-Making Capacity and Loss of Capacity

The distinction between autonomy and capacity is fundamental to the subject of surrogate decision-making. Capacity concerns the patient's ability to make a particular decision at a particular time; autonomy concerns the normative authority of the individual to make decisions concerning his or her own life. A patient may therefore retain autonomy while temporarily or permanently losing the functional capacity required to exercise it personally.

Decision-making capacity is generally assessed by examining whether an individual can understand relevant information, appreciate the consequences of the available alternatives, reason about those alternatives and communicate a choice. Capacity is consequently decision-specific and not necessarily global. A person who is incapable of making a complex medical decision may nevertheless retain the capacity to make other decisions. This distinction is particularly significant in law because declaring a person generally incapable of decision-making may unnecessarily displace the individual's remaining autonomy

The problem becomes considerably more complex where incapacity is prolonged or irreversible. In such circumstances, healthcare professionals and family members may have to make decisions concerning continuation, limitation or withdrawal of treatment without being able to obtain the patient's contemporaneous consent. The ICMR's consensus framework expressly distinguishes between healthcare decision-making capacity and surrogate decision-making, reflecting the need for an alternative mechanism where direct patient participation is impossible.

Indian clinical literature has also identified the practical difficulties surrounding surrogate decisions. In practice, family members frequently become involved in medical decision-making, particularly where the patient cannot communicate. However, family participation does not necessarily mean that the family's own preferences should replace those of the patient. Research comparing medical decision-making practices in India and the United States has observed that surrogate decisions in India are often undertaken collectively by family members, while also noting the possibility of conflict and uncertainty concerning the surrogate's proper role.

This creates the central conceptual transition for the present research: When a patient loses capacity, the law must determine not merely who can make the decision, but whose interests, values and preferences that decision is legally intended to represent.

That question leads directly to the two principal standards of surrogate decision-making: substituted judgment and best interests: which become crucial when examining the withdrawal of life-sustaining treatment.

2.3 Life-Sustaining Treatment: Meaning, Forms and Legal Significance

Life-sustaining treatment refers to medical interventions that maintain or replace essential bodily functions when those functions are insufficient to sustain life independently. Such interventions may include mechanical ventilation, cardiopulmonary resuscitation (“CPR”), vasopressor support, renal replacement therapy, artificial nutrition and hydration, and other forms of intensive medical intervention. The Indian Council of Medical Research (“ICMR”) has placed life-sustaining treatment within the broader framework of end-of-life care and distinguishes it

from measures directed primarily towards the relief of pain and suffering. The distinction is significant because the objective of end-of-life medicine is not necessarily to prolong biological existence at all costs, but to determine whether a particular intervention remains proportionate to the patient's clinical condition, prognosis and expressed wishes.

The increasing ability of modern medicine to sustain physiological functions has consequently generated a distinction between prolonging life and prolonging the process of dying. A treatment may successfully maintain respiration, circulation or nutrition while having little or no effect on the underlying irreversible disease. The ethical difficulty arises when the burdens associated with continued intervention outweigh its expected therapeutic benefit. The Indian Society of Critical Care Medicine ("ISCCM") and the Indian Association of Palliative Care ("IAPC") have therefore recognised the need to distinguish treatment directed towards recovery from treatment that merely prolongs the dying process, while emphasising that a transition from curative treatment to comfort-oriented care does not amount to abandonment of the patient.

2.3.1 Withholding and Withdrawal of Life-Sustaining Treatment

A crucial distinction in end-of-life decision-making is between withholding and withdrawing life-sustaining treatment. Withholding occurs where a treatment is not initiated or an existing treatment is not escalated. Withdrawal, by contrast, involves discontinuing an intervention that is already being administered. Thus, a decision not to intubate a terminally ill patient and a decision to remove an already established ventilatory support are conceptually different clinical actions, even though both may ultimately permit death from the underlying disease.

The ICMR specifically distinguishes the two concepts: withholding involves a decision not to initiate or escalate life-sustaining treatment where the anticipated burden outweighs the possible benefit, whereas withdrawal involves ceasing or removing an intervention that is already being provided in circumstances where continued treatment is unlikely to provide sufficient benefit. This distinction is particularly relevant to the present study because withdrawal necessarily raises a more difficult question of authority: who is entitled to determine that an existing treatment should no longer continue when the patient cannot make the decision personally?

Contemporary Indian critical-care guidance treats withholding and withdrawal as ethically grounded in the same principle. The 2024 ISCCM–IAPC consensus statement expressly states that withholding and withdrawal are ethically similar and legally equivalent. The significance of this position lies in shifting the focus away from the physical act of discontinuing treatment towards the underlying justification for the decision. The central question is therefore not whether treatment has already commenced, but whether continuing that treatment remains consistent with the patient's wishes, interests and medically appropriate goals of care.

2.3.2 Life-Sustaining Treatment and Medical Futility

The concept of medical futility introduces another important dimension. Traditionally, treatment may be regarded as futile where it cannot achieve its intended physiological or therapeutic objective. However, the term has attracted criticism because a judgment that treatment is “futile” may inadvertently suggest that the patient's life itself has no value. The ISCCM–IAPC position statement consequently cautions against using the term uncritically and favours a more careful assessment of whether treatment is potentially inappropriate or incapable of achieving a meaningful therapeutic objective.

This distinction is especially important in surrogate decision-making. A physician may determine that continued mechanical ventilation is unlikely to reverse the underlying disease, but that medical conclusion does not by itself answer the legal question of whether treatment may be withdrawn. The medical assessment establishes the clinical circumstances; the subsequent decision requires consideration of the patient's wishes, advance directives, applicable legal safeguards and, where necessary, the patient's best interests.

2.3.3 Withdrawal of Life Support and Euthanasia

Withdrawal of life-sustaining treatment must also be distinguished from active euthanasia. In active euthanasia, death is intentionally caused through a deliberate intervention undertaken for that purpose. Withdrawal of life-sustaining treatment, by contrast, involves discontinuing an intervention that is maintaining physiological functions, allowing the underlying disease or

medical condition to take its natural course. The intention and causal structure of the two situations are therefore materially different. The ICMR's terminology framework separately identifies euthanasia, withholding treatment and withdrawing treatment, reflecting the importance of maintaining these conceptual distinctions in Indian end-of-life discourse.

Similarly, withdrawal should not be equated with abandonment of care. Once life-prolonging treatment is withdrawn, the patient's entitlement to appropriate palliative care does not disappear. Contemporary Indian clinical guidance emphasises that the transition from treatment intended to prolong life to treatment focused on comfort should involve continued management of pain, breathlessness, anxiety and other forms of suffering. Consequently, withdrawal of life-sustaining treatment is not a withdrawal of medical care; rather, it represents a change in the goals of medical care.

The legal significance of these distinctions becomes particularly pronounced where the patient lacks decision-making capacity. If treatment is continued solely because the patient cannot personally object to it, the absence of present communication may effectively transform medical treatment into an automatic presumption in favour of continued biological existence. Conversely, permitting relatives or physicians to discontinue treatment solely on their own assessment risks replacing patient autonomy with the preferences or judgments of others. The law must therefore construct a framework in which the limitation of life-sustaining treatment remains anchored in the patient's rights and interests while incorporating appropriate medical and procedural safeguards.

This conceptual distinction provides the foundation for examining the surrogate decision-maker: once a patient can no longer determine whether life-sustaining treatment should continue, the crucial issue is not simply whether treatment can be withdrawn, but whose decision can legitimately stand in the place of the patient's own decision.

3. SURROGATE DECISION-MAKING: LEGAL AND ETHICAL FOUNDATIONS

3.1 Meaning and Necessity of Surrogate Decision-Making

Surrogate decision-making arises when a patient is unable to make or communicate an informed healthcare decision because of a temporary or permanent loss of decision-making capacity. In such circumstances, another person is required to participate in decisions concerning the patient's medical treatment. The surrogate does not ordinarily acquire an unrestricted authority over the patient's medical care merely by virtue of being a relative. Rather, the legitimacy of surrogate decision-making derives from the need to protect the interests and, as far as possible, preserve the autonomous choices of a person who is unable to exercise them directly.

The necessity for such a mechanism becomes particularly apparent in end-of-life situations. Decisions concerning cardiopulmonary resuscitation, mechanical ventilation, artificial nutrition and hydration, or other life-sustaining interventions may have to be taken when the patient is unconscious or otherwise incapable of expressing a preference. Leaving such decisions entirely unresolved may itself result in treatment being continued by default. At the same time, permitting another individual to make an entirely independent choice risks transforming surrogate authority into substituted personal discretion.

The ethical literature therefore treats the surrogate's role as representative rather than proprietary. The surrogate is not the owner of the decision; the surrogate is expected to exercise decision-making authority on behalf of the patient. This distinction is particularly important in India, where family members frequently play a significant role in healthcare decisions. Studies of medical decision-making in India have observed that healthcare choices are often made within a family-oriented social structure, making the relationship between individual autonomy and family participation more complex than the strictly individualistic model traditionally assumed in Western bioethics.

The ICMR recognises a surrogate decision-maker as a person who participates in healthcare decisions for a patient who lacks decision-making capacity. Its framework further emphasises that surrogate decision-making should be directed towards determining the patient's preferences and interests rather than simply expressing the surrogate's own wishes.

This raises the central question of surrogate authority: what standard should a surrogate apply when deciding for an incapacitated patient?

Two principal approaches have developed in medical ethics and law: substituted judgment and the best-interests standard.

3.2 The Substituted Judgment Standard

The substituted judgment standard attempts to preserve the patient's autonomy by asking what decision the patient would have made if capable of deciding personally. The surrogate therefore attempts to reconstruct the patient's preferences from available evidence, including previous statements, advance directives, religious or philosophical beliefs, attitudes towards medical treatment, and conversations with family members or healthcare professionals.

The underlying justification is that incapacity should not erase a person's previously expressed values. If an individual had clearly stated, while competent, that he or she would not want prolonged mechanical ventilation in circumstances involving irreversible unconsciousness, respecting that preference through a surrogate decision may be understood as a continuation of the individual's autonomy rather than the exercise of someone else's independent authority.

Substituted judgment is therefore particularly compatible with the principle of precedent autonomy. The concept recognises that an individual's autonomy may have continuing significance even after the person loses the present ability to make decisions. Ronald Dworkin's analysis of autonomy and end-of-life decision-making is particularly influential in this regard. Dworkin distinguishes between decisions based upon immediate experiential interests and a person's broader understanding of the value and meaning of his or her life, arguing that end-of-life choices may need to respect the individual's previously formed values and critical interests.

However, substituted judgment has an inherent evidentiary difficulty. The surrogate may not actually know what the patient would have wanted. Family members can possess different

understandings of the patient's preferences, and retrospective reconstruction may be influenced by grief, personal beliefs, financial considerations or disagreement within the family. The more uncertain the evidence concerning the patient's wishes, the greater the danger that “substituted judgment” becomes merely the surrogate's own preferred outcome.

Consequently, substituted judgment works most convincingly where the patient's preferences are specific, consistent and independently supported by evidence. It becomes progressively more difficult where the patient never discussed end-of-life treatment or where the available evidence is ambiguous.

3.3 The Best-Interests Standard

Where the patient's wishes cannot reasonably be determined, decision-making may instead proceed according to the best-interests standard. Under this approach, the central question is not what the patient would have chosen but what decision would most appropriately serve the patient's interests in the circumstances.

The best-interests assessment may consider the patient's medical condition, prognosis, potential benefits and burdens of treatment, pain and suffering, prospects of recovery, previously expressed values and the overall objectives of care. The standard therefore attempts to balance the preservation of life against the burdens imposed by continued treatment.

The best-interests approach is particularly significant where there is no advance directive and insufficient evidence of the patient's previous wishes. It prevents the absence of an explicit preference from automatically requiring indefinite continuation of treatment. At the same time, it creates a difficult normative question: who determines what constitutes the patient's “best interests”?

This question becomes especially important when the patient is permanently unconscious or has an irreversible medical condition. Medical professionals may evaluate the clinical consequences of treatment, while family members may possess knowledge concerning the patient's values and

personality. Neither perspective is necessarily sufficient by itself. The medical team may understand the prognosis but lack knowledge of the patient's personal values; conversely, relatives may understand the patient's values but lack the medical expertise necessary to evaluate treatment options.

The ICMR framework consequently envisages surrogate decision-making as a process requiring consideration of both the patient's previously expressed wishes and the patient's best interests, rather than treating either factor as universally determinative.

3.4 Substituted Judgment and Best Interests: The Indian Position

The distinction between the two standards is particularly relevant to India because end-of-life decisions may occur without a formally executed advance medical directive. Where a clear advance directive exists, the patient's own instructions provide a comparatively direct expression of autonomy. Where it does not exist, however, healthcare professionals and family members may have to reconstruct the patient's wishes or assess what course of action is consistent with the patient's interests.

The Supreme Court's end-of-life jurisprudence has increasingly attempted to accommodate both considerations. The constitutional recognition of the right to refuse medical treatment places the patient's autonomy at the centre of the analysis, while the procedural safeguards governing incapacitated patients recognise the need for medical assessment and independent scrutiny. The result is not an absolute preference for either the family or the medical profession.

This is significant because surrogate decision-making should not be confused with family consent. A family member may be consulted because of his or her relationship with the patient, but the legal and ethical purpose of that participation is to assist in determining the patient's wishes or interests. The surrogate's personal preference should not automatically displace the patient's autonomy.

The distinction can therefore be expressed as follows:

Substituted judgment asks: “What would this patient have chosen?” Best interests asks: “What decision most appropriately protects this patient's welfare when his or her wishes cannot be established?”

The two standards may sometimes lead to the same outcome, but they are conceptually different. A rigorous Indian framework must therefore identify which standard applies in particular circumstances and establish safeguards against the surrogate's personal interests being substituted for those of the patient.

3.5 Surrogate Decision-Making and Continuing Autonomy

The deeper legal question is whether autonomy ends when decision-making capacity ends. If autonomy is understood solely as the present ability to make a choice, incapacity would necessarily terminate it. If, however, autonomy includes the right of an individual to have previously expressed values and preferences respected after loss of capacity, then autonomy can continue to influence decision-making through advance directives and surrogate mechanisms.

This latter conception is particularly important in end-of-life law. The purpose of a surrogate is not simply to fill a decision-making vacuum. Rather, surrogate decision-making can serve as a legal mechanism for carrying the patient's autonomy across the boundary created by incapacity.

Accordingly, the legitimacy of surrogate decision-making depends upon maintaining a clear hierarchy: Patient's current competent decision → valid advance directive → reliable evidence of the patient's wishes → substituted judgment → best-interests assessment where the patient's wishes cannot reasonably be established.

This hierarchy also demonstrates why surrogate authority cannot be treated as an unrestricted power to decide whether another person's life should be prolonged or allowed to take its natural course. Its justification lies in its connection to the patient, not in the surrogate's relationship to the patient.

4. CONSTITUTIONAL AND JUDICIAL DEVELOPMENT OF END-OF-LIFE DECISION-MAKING IN INDIA

This is the next major section. Here we move from the conceptual framework into the Indian legal framework, tracing how Indian courts have developed the law governing refusal and withdrawal of life-sustaining treatment.

4.1 Article 21 and the Constitutional Basis of End-of-Life Autonomy

The constitutional foundation of end-of-life decision-making in India lies principally in Article 21 of the Constitution, which guarantees that no person shall be deprived of life or personal liberty except according to procedure established by law. The provision has progressively been interpreted by the Supreme Court as protecting not merely biological existence but a life accompanied by dignity, autonomy and meaningful personal choice. This expanded understanding is significant in the context of medical treatment because the preservation of life cannot necessarily be separated from the individual's authority to determine what medical interventions may be imposed upon his or her body.

The constitutional significance of autonomy was strengthened through the Supreme Court's broader privacy jurisprudence. In K.S. Puttaswamy (Retd.) v. Union of India, the Constitution Bench recognised decisional autonomy as an essential component of personal liberty and privacy. Although Puttaswamy was not an end-of-life case, its recognition of an individual's authority over intimate personal decisions provides an important constitutional foundation for understanding medical autonomy.

The relationship between Article 21 and medical treatment therefore involves two potentially competing dimensions of the right to life. On one hand, the State has a legitimate interest in protecting human life. On the other, an individual possesses a constitutionally protected interest in determining what may be done to his or her body and, in appropriate circumstances, whether burdensome medical intervention should be continued. The constitutional question is

consequently not simply whether life should be preserved, but whether preservation of biological life can legitimately be imposed contrary to the autonomous wishes and dignity of the individual. This tension forms the constitutional background against which the Supreme Court developed its jurisprudence on passive euthanasia and withdrawal of life-sustaining treatment.

4.2 Aruna Ramachandra Shanbaug v. Union of India: The Beginning of Judicial Recognition

The Supreme Court's decision in Aruna Ramachandra Shanbaug v. Union of India marked an important stage in the development of Indian end-of-life jurisprudence. The case concerned Aruna Shanbaug, a nurse who had remained in a persistent vegetative state for several decades following a brutal assault. A petition was filed seeking permission for the withdrawal of life-sustaining measures.

The Court distinguished between active euthanasia and what it described as passive euthanasia. Active euthanasia involves a positive act intended to cause death, whereas passive euthanasia involves withholding or withdrawing medical treatment necessary to sustain life. The Court rejected the legalisation of active euthanasia but recognised that, under strictly controlled circumstances, withdrawal of life-sustaining treatment could be permissible.

The judgment also introduced a distinction between patients who possess decision-making capacity and those who do not. Where a competent patient refuses medical treatment, the question primarily concerns the patient's own decision. Where the patient lacks capacity, however, the Court considered that the decision could not simply be left to an individual relative or physician acting independently. Judicial oversight and a determination of the patient's best interests were therefore incorporated into the framework.

The significance of Aruna Shanbaug lies not merely in its recognition of passive euthanasia. It represented an early attempt to reconcile three competing interests: preservation of life, patient autonomy and protection of vulnerable patients from potentially arbitrary decisions.

However, the framework established in Aruna Shanbaug was subsequently regarded as procedurally cumbersome and insufficiently aligned with the constitutional development of individual autonomy. Its approach was therefore substantially reconsidered by the Supreme Court in Common Cause.

4.3 Common Cause v. Union of India: Right to Die with Dignity

The constitutional position underwent a significant transformation in Common Cause (A Registered Society) v. Union of India. A Constitution Bench considered whether the right to die with dignity formed part of the right to life under Article 21 and whether an individual could execute an advance medical directive concerning future medical treatment.

The Court recognised that the right to life under Article 21 includes the right to live with dignity and that such dignity extends to the final stage of life. The Court consequently recognised the right to refuse medical treatment and held that a competent individual could decide against the continuation of life-sustaining medical intervention.

A particularly significant aspect of the judgment was its recognition of advance medical directives. An advance directive enables an individual, while possessing decision-making capacity, to communicate preferences regarding medical treatment in anticipation of a future period of incapacity. It therefore provides a mechanism through which autonomy can continue to operate even when the individual is no longer capable of communicating personally.

The judgment is particularly relevant to surrogate decision-making because it places the patient's own previously expressed wishes ahead of an independent decision by relatives or medical practitioners. The surrogate mechanism is therefore not intended to create a new autonomous authority in the family; rather, it functions within a broader legal structure designed to respect the patient's previously expressed choices and, where those choices cannot be established, protect the patient's interests.

The Court's recognition of passive euthanasia was consequently better understood as part of the broader constitutional principle of end-of-life autonomy, rather than as an unrestricted constitutional right to obtain death.

4.4 Procedural Framework and the 2023 Modification

Although Common Cause established the constitutional foundation for advance directives and withdrawal of life-sustaining treatment, the procedural requirements prescribed by the Court raised significant practical concerns concerning implementation. In 2023, the Supreme Court revisited and modified the safeguards governing advance medical directives and the withdrawal of life-sustaining treatment.

The modified framework sought to make the mechanism more workable by reducing procedural obstacles while retaining institutional safeguards against arbitrary decisions. The Court maintained the importance of medical assessment and independent scrutiny, thereby recognising that end-of-life decisions involving incapacitated patients cannot depend solely upon the wishes of relatives or the unilateral judgment of an individual physician.

The significance of the 2023 modification is therefore twofold. First, it demonstrates that constitutional recognition of end-of-life autonomy requires an operational legal mechanism. Secondly, it highlights the continuing tension between facilitating patient autonomy and ensuring sufficient safeguards for vulnerable patients.

4.5 Emerging Judicial Approach to Clinically Assisted Nutrition and Hydration

The legal debate has subsequently expanded beyond conventional forms of life support to questions concerning clinically assisted nutrition and hydration. This development is important because nutrition and hydration may be perceived intuitively as basic forms of care rather than medical treatment, yet their administration through medical means can become a significant component of life-sustaining treatment in patients lacking capacity.

The Supreme Court's recent consideration of this issue demonstrates that Indian end-of-life jurisprudence continues to evolve beyond the traditional active/passive euthanasia distinction. The focus is increasingly directed towards questions such as the patient's condition, prognosis, capacity, previously expressed wishes, proportionality of treatment, and the patient's overall best interests.

This development is particularly significant for surrogate decision-making because disputes concerning clinically assisted nutrition and hydration may arise precisely when the patient cannot communicate and family members disagree about whether treatment constitutes necessary care or burdensome life-sustaining intervention.

4.6 From Judicial Permission to Patient-Centred Decision-Making

The trajectory of Indian jurisprudence reveals a broader transformation in the legal understanding of end-of-life treatment. The approach has gradually moved from a model dominated by judicial control over withdrawal of treatment towards a framework that places greater emphasis on patient autonomy, advance directives, medical assessment and structured decision-making.

The progression may broadly be understood as:
Aruna Shanbaug (2011) ; judicial recognition of withdrawal of life support in limited circumstance
Common Cause (2018); constitutional recognition of dignity, autonomy and advance directives
Common Cause (2023) ; modification and operationalisation of procedural safeguards.

Subsequent jurisprudence further refinement of best-interests analysis and treatment-specific questions. The significance of this evolution for surrogate decision-making is substantial. The modern Indian framework does not treat incapacity as an automatic transfer of the patient's decision-making authority to the family. Instead, it requires the decision-maker to operate within a legal and medical framework directed towards determining and protecting the patient's wishes, dignity and interests.

This leads to the next central issue of the research: where the patient has not left an advance directive, how should the law determine who may act as a surrogate and what standard that surrogate must apply?

5. ADVANCE MEDICAL DIRECTIVES AND THE PRESERVATION OF PATIENT AUTONOMY

An advance medical directive ("AMD") is a mechanism through which a person, while possessing decision-making capacity, records instructions concerning medical treatment to be followed if the person subsequently becomes incapable of making or communicating healthcare decisions. In the context of life-sustaining treatment, an AMD allows an individual to express preferences regarding the continuation, withholding or withdrawal of particular forms of treatment. It therefore operates as a means of extending patient autonomy beyond the point at which the individual loses decisional capacity.

The importance of an AMD lies in its ability to reduce uncertainty regarding the patient's wishes. Without such a directive, decisions may have to be reconstructed from conversations with relatives or inferred from the patient's general values. This creates the possibility that the preferences of family members, rather than those of the patient, may ultimately determine the course of treatment. An AMD provides comparatively direct evidence of the patient's own decision and consequently strengthens the principle that end-of-life treatment should be guided by the patient's wishes wherever legally and medically applicable.

In Common Cause (A Registered Society) v. Union of India, the Supreme Court recognised the constitutional validity of advance medical directives as an expression of the individual's right to autonomy and dignity under Article 21. The Court's recognition was significant because it shifted the focus from determining whether another person should be permitted to make an end-of-life decision towards respecting a decision that the patient had already made while competent.

However, an AMD does not eliminate every difficulty. Medical circumstances may differ substantially from those anticipated by the patient when the directive was prepared. A broadly worded instruction may also create uncertainty regarding whether it applies to a particular clinical situation. Consequently, the interpretation of an AMD requires consideration of both the wording of the directive and the medical circumstances in which it is sought to be implemented.

The 2023 modifications to the Supreme Court's framework attempted to make the implementation of advance directives more practicable while retaining safeguards against misuse.[3] The involvement of medical boards and procedural verification reflects the recognition that an advance directive involves both an autonomous decision and a clinical determination concerning its applicability.

An AMD also has an important relationship with surrogate decision-making. Where a valid and applicable directive clearly expresses the patient's wishes, the surrogate's role should principally be to facilitate implementation rather than substitute a different personal preference. The surrogate becomes particularly important where no directive exists, where its meaning is uncertain, or where the clinical circumstances differ materially from those contemplated by the patient.

The concept nevertheless faces practical challenges in India. Awareness of advance directives remains limited, and individuals may be reluctant to discuss death or future incapacity. There may also be difficulties concerning documentation, accessibility of the directive to treating physicians, interpretation of medical terminology, and disagreements among relatives regarding the patient's actual wishes. The effectiveness of an AMD therefore depends not merely upon its legal recognition but upon its accessibility and integration into the healthcare system.

Ultimately, the advance medical directive represents an important bridge between autonomy and incapacity. It demonstrates that the loss of decision-making capacity need not necessarily result in the loss of the patient's voice. Where a person's wishes have been clearly and validly expressed beforehand, surrogate decision-making should ordinarily operate in a manner consistent with those wishes rather than replacing them.

6. CRITICAL ANALYSIS: AUTONOMY, DIGNITY AND COMPETING INTERESTS

The Indian framework for withdrawal of life-sustaining treatment attempts to reconcile two principles that may appear contradictory: the preservation of life and the individual's right to live and die with dignity. Patient autonomy requires that a competent individual should be able to refuse medical treatment, even where such refusal may result in death. However, when the patient loses decision-making capacity, autonomy can no longer operate directly and must be preserved through advance directives or surrogate decision-making.

A significant difficulty arises when the patient's wishes are unknown. In such circumstances, the best-interests standard becomes necessary but also introduces an element of subjectivity. Family members may possess valuable knowledge about the patient's values and preferences, yet their own emotional, cultural or financial interests may influence their judgment. Indian scholarship has therefore highlighted the importance of distinguishing the patient's interests from the preferences of relatives who participate in the decision-making process. The surrogate should represent the patient, rather than become the ultimate owner of the decision.

The concept of dignity further complicates the analysis. Dignity cannot be reduced merely to physical independence or the absence of disability. At the same time, it should not be used to suggest that lives involving severe disability or dependency are inherently undignified. The relevant question is whether continued medical intervention provides meaningful benefit to the patient or merely prolongs biological existence without therapeutic purpose. The Supreme Court's approach in Harish Rana reflects this distinction by requiring consideration of treatment benefit, futility, medical evidence, the patient's welfare and relevant non-medical circumstances.

There is also a broader institutional concern. Excessive judicial or procedural control may delay decisions and impose additional burdens upon families and healthcare professionals, whereas insufficient safeguards may expose vulnerable patients to arbitrary withdrawal of treatment. The challenge, therefore, is to construct a framework that protects autonomy without transforming family consent or medical opinion into an unrestricted power over the patient

Ultimately, the Indian approach should be understood as an attempt to preserve autonomy even after capacity is lost. Dignity, in this context, is not a justification for ending life; rather, it requires that medical treatment remain proportionate to the patient's condition, wishes and welfare, while ensuring that withdrawal of treatment is accompanied by continuing palliative care.

7. CHALLENGES IN THE INDIAN CONTEXT

Despite the development of a formal legal framework for end-of-life decision-making, its practical implementation in India remains difficult. The first major challenge is limited awareness of advance medical directives. Many patients and families are unfamiliar with the legal possibility of recording treatment preferences in advance, reducing the effectiveness of autonomy-based decision-making when capacity is lost.

A second difficulty is the uneven availability of medical expertise and institutional infrastructure. The functioning of Medical Boards and multidisciplinary decision-making may be relatively feasible in major tertiary hospitals but considerably more difficult in smaller hospitals and rural areas. Differences in access to intensive care, palliative care and trained professionals can therefore affect the practical application of the same legal standards.

Another concern is the predominant role of family members in medical decisions. Family involvement can be valuable because relatives often understand the patient's values and preferences. However, it may also create a risk that the family's economic, emotional or cultural interests will influence decisions that should ultimately reflect the patient's wishes. This becomes particularly significant where no advance directive exists.

The framework also faces difficulties concerning medical uncertainty. Prognosis is not always capable of precise prediction, particularly in cases involving neurological injury or prolonged intensive care. Consequently, determining whether continued treatment offers meaningful benefit may involve legitimate disagreement among medical professionals.

Finally, financial and social realities cannot be ignored. Prolonged intensive treatment may impose substantial costs on families, while access to palliative care remains uneven. End-of-life law must therefore operate alongside stronger palliative-care systems, clearer institutional protocols and greater public awareness.

The central challenge is consequently not merely the absence of legal rules, but ensuring that those rules can be applied consistently, ethically and realistically across India's diverse healthcare system.

8. COMPARATIVE LEGAL PERSPECTIVE

A comparison with other jurisdictions demonstrates that surrogate decision-making and withdrawal of life-sustaining treatment are generally governed by principles of autonomy, substituted judgment and best interests, although their institutional mechanisms differ.

In the United States, the Patient Self-Determination Act, 1990 requires healthcare institutions receiving certain federal funds to inform patients of their rights concerning advance directives and medical decision-making. American law therefore places considerable emphasis on preserving a patient’s preferences after loss of capacity. Where no directive exists, surrogate decision-making generally operates through substituted judgment or, where the patient’s wishes are unknown, the best-interests standard.

The United Kingdom adopts a somewhat different statutory framework. Under the Mental Capacity Act 2005, a person who lacks capacity must have decisions made in accordance with their best interests, while advance decisions to refuse specified medical treatment may be legally binding if statutory requirements are satisfied. The Act also requires decision-makers to consider the person’s past and present wishes, feelings, beliefs and values.

India shares elements of both approaches. Like the United States, it recognises advance medical directives as an instrument for preserving individual autonomy. At the same time, the Indian framework places significant emphasis on medical assessment and institutional safeguards

through Medical Boards. This reflects an attempt to balance individual choice with protection against erroneous or arbitrary withdrawal of treatment.

The comparative experience also demonstrates that legal recognition alone is insufficient. Effective end-of-life decision-making requires public awareness, accessible advance-care planning, trained healthcare professionals and reliable mechanisms for resolving disagreement. India's continuing challenge is therefore to translate its constitutional recognition of dignity and autonomy into a system that remains workable across different healthcare settings.

9. RECOMMENDATIONS AND WAY FORWARD

The development of India's end-of-life framework demonstrates significant judicial progress, but its effectiveness ultimately depends upon consistent implementation. Several measures may strengthen the existing system.

First, greater awareness of advance medical directives is necessary. Patients should be informed about their right to document treatment preferences, particularly during serious illness or admission to healthcare institutions. Hospitals can incorporate advance-care planning into appropriate stages of patient counselling.

Second, India requires clear and uniform institutional protocols for withholding or withdrawing life-sustaining treatment. Although the Supreme Court has established safeguards, hospitals should maintain standard procedures for documentation, communication with families, medical assessment and referral to the appropriate Medical Board. This would reduce uncertainty among healthcare professionals.

Third, access to palliative and end-of-life care should be strengthened. Withdrawal of life-sustaining treatment must never mean abandonment of the patient. Appropriate pain management, symptom control, psychological support and communication with families should remain available throughout the dying process.

Fourth, healthcare professionals require greater legal and ethical training in end-of-life decision-making. Doctors should be able to distinguish between lawful withdrawal of medically inappropriate treatment and active measures intended to cause death. Multidisciplinary ethics committees may also assist in resolving difficult cases before disputes reach courts.

Finally, the framework should remain patient-centred rather than procedure-centred. Medical Boards and legal safeguards are necessary, but they should facilitate the patient's wishes rather than create unnecessary procedural barriers. Greater public awareness, accessible palliative care and effective advance-care planning can collectively reduce the dependence on emergency family decisions and prolonged litigation.

The objective of reform should therefore not be to make withdrawal of treatment easier or more difficult in the abstract, but to ensure that decisions are made lawfully, transparently and consistently with the patient's autonomy, dignity and welfare.

10. CONCLUSION

The withdrawal of life-sustaining treatment represents one of the most difficult intersections of law, medicine and ethics. In India, the legal position has gradually moved from a predominantly life-preserving approach towards a framework that recognises patient autonomy, dignity and the right to refuse medical treatment, while retaining safeguards against arbitrary decisions.

Surrogate decision-making becomes particularly significant when a patient loses decision-making capacity. However, the surrogate's authority should remain representative rather than personal. The patient's known wishes should guide the decision wherever possible, while the best-interests standard becomes relevant when those wishes cannot reasonably be established. Advance medical directives provide an important mechanism for preserving autonomy beyond the point at which a patient can communicate independently.

The Supreme Court's jurisprudence, particularly Aruna Shanbaug and Common Cause, together with subsequent procedural developments, has created a structured framework involving medical professionals and Medical Boards. Nevertheless, legal recognition alone cannot resolve the

practical difficulties surrounding end-of-life decisions. Limited awareness, unequal healthcare infrastructure, uncertainty in prognosis, family pressures and inadequate access to palliative care continue to affect implementation.

Ultimately, the legitimacy of withdrawing life-sustaining treatment lies not in choosing between preserving life and respecting autonomy as competing absolutes, but in ensuring that medical intervention remains consistent with the patient's wishes, dignity and welfare. India's future approach should therefore strengthen advance-care planning, palliative care, professional guidance and accessible institutional safeguards. A patient-centred system can ensure that when autonomy is lost through incapacity, it is not necessarily lost through the decision-making process itself.