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Passive Euthanasia after Common Cause vs Union of India Constitutional Transformations in End-of-Life Decision Making

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Abstract

The concept of passive euthanasia was introduced in India through the historic judgment of Common Cause v. Union of India, which brought about a significant shift in the landscape of end-of-life decisions and patient autonomy in the country. The ruling broadened the interpretation of Article 21 of the Constitution, which guarantees the right to life and the right to die with dignity under certain, restricted and regulated conditions. It legalized passive euthanasia and acknowledged the validity of the advance medical directives or living wills, thus establishing a precedent in favor of the withdrawal or withholding of life-sustaining treatment from terminally ill patients. This is a change from the state-centered approach to life preservation to a patient-centered approach based on dignity, autonomy, privacy and informed consent. Through an analysis of judicial rulings, ethical challenges and international practices, the Constitutional basis of passive euthanasia in India is critically examined. It also highlights the functions of medical practitioners, safeguards to be taken and the ongoing difficulties in enforcing the directive issued by the Supreme Court. In addition, the study assesses the individual liberty versus the state's interest in preserving life, and the changing nature of the relationship between constitutional morality, medical ethics and human rights jurisprudence. The paper's key findings are that the judgment moves towards a more compassionate approach to healthcare governance and dignified end of life treatment in the Indian constitutional context.

Keywords: Passive Euthanasia**,** Right to Die with Dignity**,** Article 21**,** Living Will**,** End-of-Life Decision-Making

1. Introduction

Passive euthanasia occurs when medical treatment is withheld or removed from a patient because they are terminally ill, permanently unconscious or have irreversible medical issues that have no reasonable expectation of improvement. Passive euthanasia is not the purposeful ending of life, as with active euthanasia, but rather the failure to provide the extra support needed to sustain life, such as withholding a ventilator, feeding or resuscitation. Debate around euthanasia has always raised deep legal, ethical, religious and constitutional issues as it directly raises questions on the sanctity of the human life, autonomy of individuals, medical ethics and the role of the State in regulating personal decisions on the issue of death and dignity.

However, the legal and constitutional debate on euthanasia in India did not take the form of a legislative process, but rather through judicial interpretation. In the past, India's criminal law classified any type of help in committing suicide as a crime under the Indian Penal Code,

Sections 306 and 309, which address abetment of suicide and attempted suicide respectively. Preservation of life has been a historical central constitutional and social value. In the years that have passed however, medical science, life sustaining technology, and heightened consciousness of patient rights has created complicated circumstances where patients were maintained on life support without any sign of healing or recovery. In this context, the question arose whether it is cruel to prolong the biological life of the person without giving him his dignity, whether such a situation is an infringement of constitutional freedoms.

The debate was first given constitutional importance in the context of interpretation of Article 21 of the Indian Constitution, which guarantees protection of life and personal liberty. Over time, the definition of Article 21 also evolved to include the right to live with dignity, privacy, autonomy, and bodily integrity. This led to the development of the view that the right to a dignified death should also be included in securing a dignified life. This debate gained importance when applied to terminal ill, permanent vegetative state and irreversible suffering situations where medical care only extended the duration of the suffering rather than extended the life.

The issue was first discussed in P. Rathinam v. Union of India, in which the Supreme Court briefly acknowledged the right to die as a part of Article 21. But that was later reversed in Gian Kaur v. State of Punjab, where the Court ruled that the right to die was not included in the right to life. However, the landmark ruling made the important observation that the right to die with dignity in the case of a terminal illness may come under the protections of Article 21. This observation later would serve as the bases for the constitution to recognize the concept of passive euthanasia.

An important judgment in Indian euthanasia law has come from Aruna Ramachandra Shanbaug vs Union of India. The case involved a nurse who had been downed in a vicious assault, and was in a persistent vegetative state for many decades. Though the plea for active euthanasia was rejected by the Supreme Court, it had allowed for passive euthanasia under exceptional circumstances and had introduced procedural safeguards, which included that the withdrawal of life support would require an approval from the High Courts. This judgment recognized some circumstances in which it was not wrong to let death come, as opposed to causing it.

2. Constitutional Dimensions of the Right to Die with Dignity under Article 21

Art. 21 of the Constitution of India guarantees the right to life and personal liberty, which cannot be taken away except by procedure established by law. In the decades that followed, the meaning of Article 21 evolved from a procedure to a source of substantive human rights, due to judicial interpretation. The Supreme Court has gradually expanded the right to life to mean the right to dignity, to privacy, to livelihood, to shelter, to health care, and to autonomy. In this constitutional development the right to die with dignity became an intricate yet important facet of personal liberty and human dignity.

The debate that has raged in the Constitution is about the scope of the right to life guaranteed by Article 21, does it mean that a person has the right not to be given treatment whose sole purpose is to artificially prolong his life when he is suffering from a terminal illness or from a state of irreversible suffering? The traditional interpretations had seen a life as an inviolable

value and the State as an inviolable organ, which the State should protect at all costs. But it was a long time for constitutional jurisprudence to accept the concept of dignity as the essence of fundamental rights. Being able to live without consciousness, autonomy and without being able to escape from intolerable suffering does not mean that one lives in a way that is constitutionally worthy of life.

The Supreme Court first considered this question in the case of P. Rathinam v. Union of India, which invalidated Section 309, Indian Penal Code, which was punishing suicide attempts. The Court concluded that the right to live encompassed the right to not live under intolerable circumstances. The judgment "says that the very right to life is violated if someone is forced, against their will, to endure life when they are in great agony. The ruling sparked considerable controversy, but represented the first major judicial effort to link personal autonomy to choices about death.

In Gian Kaur v. State of Punjab, however, the constitutional position shifted and a Constitution Bench struck down Rathinam's view by saying that the right to life guaranteed by Article 21 of the Constitution of India does not include the right to die. The Court pointed out that life is one of the natural rights, and suicide is unnatural and contrary to the constitutional values. Despite this, an important distinction emerged in the judgment, which acknowledged that the right to die with dignity in the case of people with a terminal illness or imminent death was distinct from suicide. This principle would form the basis for the post-euthanasia jurisprudence.

Other rulings, expanding privacy and autonomy rights, reinforced the concept of dignity in the constitution. The Supreme Court in Justice K.S. Puttaswamy v. Union of India held that privacy as a right is a fundamental right in article 21 of the Indian Constitution. The ruling highlighted the importance of bodily integrity, self-determination, and choice in the context of constitutional freedom. These ideals had a profound impact on subsequent understandings of end-of-life decisions as they are directly connected to issues of bodily autonomy and personal dignity when it comes to refusing invasive medical care.

The landmark decision in Common Cause v Union of India had spells out the constitutional aspects of passive euthanasia. The Constitution Bench had opined that right to die with dignity is an integral part of Article 21. The Court argues that patients' dignity and autonomy are being violated by being forced to continue with artificial treatment when they have difficult-to-treat diseases and have a terminal prognosis. The Court acknowledged that people enjoy autonomy in regard to choices that impact their bodies and medical care, including the avoidance of life-sustaining interventions.

The judgment was heavily influenced by the issues of constitutional morality and transformative constitutionalism. Constitutional morality is the respect of the constitutional ideals of dignity, liberty, equality and justice, instead of social prejudices or the ideal of the majority. The Court's acceptance of passive euthanasia confirmed that values in the Constitution had to adapt to the new realities of human life and new discoveries in medicine. It was judgement that was marked by compassion and respect for individual choice, and a kind recognition of life and death.

The Court also highlighted the significance of informed consent in medical jurisprudence. Consent is one of the fundamental elements of personal freedom, in that every competent adult has the right to determine what medical treatment is administered, or not administered. Thus, a patient reasonably may wish to refuse life-sustaining medical treatment when it would otherwise be provided when it does not offer a reasonable chance of achieving a better outcome but likely only provides for continued suffering. This concept is in line with the universally accepted principles of bioethics that promote autonomy and patient-centred care.

3. Evolution of Judges from Gian Kaur v. State of Punjab to Common Cause v. Union of India

Passive euthanasia' in Indian jurisprudence is one of the most important constitutional and medical jurisprudential developments. From Gian Kaur v State of Punjab, a restrictive interpretation of passive euthanasia, to Common Cause v Union of India, a progressive recognition of passive euthanasia, there is a shift in the constitutional understanding of dignity, autonomy and constitutional morality. This is a judicial odyssey of the development and the evolution of the Constitution in the light of the new socio-economic context, the new medical knowledge and the new human rights principles.

Prior to Gian Kaur, the Supreme Court in the case of P. Rathinam v. Union of India had declared that the provision of Section 309 of the Indian Penal Code, which penalises attempted suicide, infringes on Article 21 of the Constitution. In the Court's reasoning, the right to life logically extended to the right not to live, particularly when life is lived under conditions of great suffering and hopelessness. The court stressed on personal liberty and human dignity, positing that compelling a person to persist in life against his/her wishes might be an unreasonable infringement on his or her autonomy. This, however, sparked considerable controversy as it seemed that it was arguing a generalised right to die.

In Gian Kaur, the constitutional situation was drastically altered. The case was a challenge to the constitutional validity of Sections 306 and 309 of the Indian Penal Code. The Constitution Bench overturned the Rathinam judgment, saying that Article 21 does not guarantee the right to die. The Court said that life is a natural right and protected by the Constitution, while suicide is an unnatural death that is contrary to the Constitution's values. The Court was concerned that allowing for a “right to die” would have the effect of undermining the sanctity of life and the State’s responsibility to protect vulnerable people.

While the Gian Kaur judgment did not recognise a general right to die, it nonetheless contributed to the doctrine in a meaningful way when used in the context of a terminal illness. The Court stated that the circumstances of natural death in cases of irreversible suffering or imminent death may arise in which a peaceful death will be consistent with dignity in line with Article 21. This observation provided the constitutional basis for the recognition of passive euthanasia in future.

Next came Aruna Ramachandra Shanbaug v. Union of India. A nurse at a Mumbai hospital, Aruna Shanbaug was beaten to a persistent vegetative state in the hospital and never regained consciousness for more than 40 years. A petition filed for permission for euthanasia placed the issue of end-of-life decisions right before the Supreme Court. The Court did not approve of

active euthanasia but accepted passive euthanasia in exceptional cases. It had ruled that pulling the plug was OK if the treatment had no therapeutic value and was only keeping the person alive in order to make their life "endure longer.

Similar concepts and principles from other countries like the United Kingdom and the United States were heavily used in the Aruna Shanbaug judgment. The Court said that passive euthanasia, which is the omission or withdrawal of extraordinary medical measures, was not the same as active euthanasia, in which deliberate actions are taken to end life. Passive euthanasia was regarded as morally and legally acceptable since death was permitted to happen naturally, rather than directly caused by the person.

Importantly, the Court has laid down procedural safeguards for approving withdrawal from life support from the appropriate High Court. Permission was to be granted by the High Court, who had to seek the advice of doctors and take into account the welfare of the patient. These measures provided for caution, but critics complained that the process was overly complicated and did not take full account of patient autonomy.

The most significant change was brought by a judgment of the Constitution Bench in Common Cause. The petition argued for the recognition of the right to die with dignity and legal enforceability of advance medical directives. The Supreme Court has unanimously ruled that passive euthanasia is constitutional and is a part of the right to life with dignity guaranteed by Article 21. The judgment held that compulsory treatment for prolonging life for the terminally ill, when there is a lack of meaningful medical prognosis, is a violation of their dignity, autonomy, and their body.

One of the most significant aspects of the Common Cause decision was the acceptance of living wills and advance directives. The Court concluded that, in situations where an individual is not able to communicate his wishes, he may designate in advance that life-support treatment be withheld or withdrawn. This recognition greatly empowered patient autonomy and helped to accept the patient's decision on death even in the absence of their capacity.

4. Legal Recognition of Living Wills and Advance Medical Directives in India

One of the most progressive aspects of the judgment passed in Common Cause v. Union of India, relates to the recognition of living wills and advance medical directives in India. The decision reshaped the medical landscape in India by establishing the constitutional right of competent persons to specify the kind and amount of medical treatment they want to receive when they are facing imminent death or irreversible disabilities. The recognition of advance directives is a sign of the increasing prominence of autonomy and informed consent and dignity in healthcare law and constitutional governance.

A Living Will is a written statement of a person's preferences for or against medical treatment if you are unable to communicate the next time you are no longer able to do so. It usually indicates if life supporting equipment like ventilators, artificial nutrition, resuscitation or invasive procedures should be continued or withdrawn if a person cannot medically recover. One of the functions of advance medical directives is to give the person the option of maintaining control over end-of-life decisions even when they can't make their own choices because they are unconscious or mentally incompetent.

Living wills were not recognized as a formal legal document in Indian law before the Common Cause judgment. Doctors, hospitals, and families made most decisions about the care of the terminally ill, leaving many to wonder about the extent to which decisions were made, the ethical issues involved, and how long patients suffered. Families often were emotionally upset and faced uncertain legal situations regarding withdrawal of treatment, and physicians were often concerned about liability for homicide or abetment of suicide. The lack of a legal framework also resulted in inconsistencies in medical practice and put patients at risk of unwanted invasive medical procedures.

The Constitution Bench in the case of Common Cause had no doubt that the right to make an advance directive is a constitutional right implied under Article 21 of the Constitution. The Court found autonomy over the body and decisions about their health to be an integral part of personal liberty and dignity. All adults are entitled to make decisions regarding their own body and its treatment including the ability to refuse "extraordinary" treatment. As a result, an individual can make in advance a decision not to have artificial life-support provided when there is no possibility of recovery, and treatment will only cause additional suffering.

The Court pointed out that living wills serve the dignity by avoiding "unnecessary and degrading prolongation of the biological life. It understood that with today's medical technology, it was possible to maintain life in the body for long periods even if the brain was irreparably damaged or a terminal disease was present. Such interventions can save biological life but at the same time they can limit an individual's life to a life without meaning, awareness, and autonomy. Respect for decisions that people make about how they end their lives is thus included in the constitutional right to dignity.

The recognition of living wills also makes a harmonization of Indian law with international trends in medical ethics and human rights. Advance directives are recognized as expressions of patient autonomy in many countries, such as the United States, Canada, Australia and in some European countries. The principle of informed consent is one of the fundamental international principles that safeguards bioethics, as is the principle of bodily integrity, and the right of individuals to refuse unwanted medical care. The recognition of living wills in India is thus a step towards aligning with the evolving global standards related to patients' rights and compassionate care.

However, there are great implementation problems. There is still low awareness of living wills and awareness of the advantages of having one, especially in rural areas and economically poorer groups. Hospitals do not have institutional policies and procedures regarding advance directives, and physicians and other health care providers are frequently not sure of their legal responsibilities. Acceptance of end-of-life decision-making practices is even more complicated by cultural and religious beliefs about death. A socio-cultural norm in Indian society is to involve family members in health care decisions and this can sometimes be at odds with the wishes of the individual expressed in a living will.

Advance directives, then, are a groundbreaking constitutional advancement. It continues to promote the concept of dignity and autonomy until death and people have the right to control their medical fate in accordance with their values and choices. The judgment marks a step

towards a more compassionate and rights-based governance of healthcare in the constitutional democracy of India.

5. Ethical, Medical, and Human Rights Issues on Passive Euthanasia

While the judgment in Common Cause v. Union of India brought significant constitutional and humanitarian developments to the table, it also presented several ethical, medical, and human rights issues. End-of-life decision making raises complex issues about the sanctity of life, physician duties, patient choice, family issues, religious values and possible misuse. These worries remain relevant in the practical and philosophical discussions on the issue of passive euthanasia in India and beyond.

One of the main ethical issues is the balance between the quality of life and the sanctity of life. Conventional moral philosophies, especially religious and cultural values, have protected the sanctity of human life and absolute inviolability of it, even if it is sick and plagued by diseases, or even if medical experts determine that it will not live long. From this point of view, withdrawal of life support treatment might seem ethically wrong since it allows death to happen. In many faiths, it is important to remember that life and death are not dictated by the will of humanity, but of God. Euthanasia is therefore regarded as disturbing or stifling natural or spiritual processes.

However, those in favor of 'passive' euthanasia say that dignity, autonomy, and relief from suffering are also crucial ethical issues. They believe that the treatment offered by modern medicine should not be only concerned with extending the patient's life but with the quality of life during this extension. The very nature of the treatment the patient undergoes when suffering from a terminal illness and has no hope of recovery can cause great physical and psychological distress. With these as ethical principles, one ought to respect the autonomy of such a person to refuse extraordinary medical measures, and do so with compassion. Passive euthanasia, from this point of view, acknowledges the dignity of human life, which allows a natural, peaceful death without unnecessary suffering.

Medical ethics also poses great difficulties. In the past, the medical profession has been directed by the Hippocratic oath, which says to do no harm and save lives. There is a concern that doctors may feel conflicted with participation in end-of-life decisions or may experience moral distress. Decisions about futility or true hopelessness will require difficult clinical evaluations which can be subject to disagreement between different medical professionals. The uncertainty on prognosis poses the risk of premature stopping of treatment where recovery may still be possible.

From a human rights point of view, there is a tension between different understandings of dignity and state responsibility in relation to passive euthanasia. The right to die with dignity is said to be an integral component of internationally recognised rights in relation to privacy, bodily integrity and freedom from inhuman treatment. In forcing a person to suffer unnecessarily for an extended period of time when they have a life-threatening illness, this action could be a violation of the dignity of that person. Patient-centered healthcare and respect of personal autonomy have grown in focus in the international human rights discourse.

But opponents warn that acceptance of euthanasia could lead to a reduction in the support for the protection of vulnerable people, including the elderly, disabled or chronically ill. Some disability rights activists contend that the legalization of euthanasia can perpetuate the implicit message that lives impacted by disability and dependency are of less value. The challenge, then, is to make sure that the laws on euthanasia do not disregard or violate the principle of equal respect for all human lives, yet uphold respect for autonomy.

Another problem is the lack of infrastructure for palliation in India. A large number of patients with terminal illnesses are without adequate pain control, counselling, hospice and emotional care. Critics say that before the State should increase the use of euthanasia, it should focus on making palliative care better. meaningful options, such as providing a compassionate healthcare service that reduces suffering but does not shorten a person's life, are required to make informed choices at the end of life.

6. Comparative Perspectives and the Future of End-of-Life Decision-Making in India

The study of the passive euthanasia in India with comparative constitutional and legal perspectives is of great significance. The Common Cause v Union of India case was heavily influenced by international laws and human rights concepts on dignity, autonomy and end of life care. Ethics and the practice of euthanasia have been handled differently in different countries in line with their constitutional systems, ethical values, medical practices, and social conditions. A comparative analysis of these models gives insights into the future pathway of end-of-life decision making in India.

The Netherlands has a statutory regulation of both active and passive euthanasia, and is one of the first countries in the world to do so. Under certain conditions, euthanasia and physician-assisted dying are allowed under the Dutch law, which requires the request to be voluntary and well considered, the suffering is intolerable and cannot be alleviated, and the treating physician consults independent medical experts. The Dutch model is based on respect for personal autonomy and compassionate care. The system also has built-in safeguards and reporting mechanisms to ensure that abuse does not occur.

Belgium also allows euthanasia in specific circumstances and has extended the age qualifications to allow some minors to receive euthanasia if they suffer from unbearable pain. The Belgian legal framework is based on the principles of patient consent, medical review and ethical oversight. There are also examples of other jurisdictions, including Luxembourg and Canada, where the forms of medical assistance in dying found in their constitution and statute recognize the dignity and liberty principle.

The United Kingdom on the other hand does not have general permission for active euthanasia but does for passive ones under judicial supervision. Withdrawal of life support was allowed, for example in Airedale NHS Trust v Bland, when continued treatment was not for therapeutic purposes in a patient in a PVS. British courts placed a sharp focus on the difference between actively causing death and letting death take its course, when a patient ceased to receive futile treatment. This gave a major impact on the Indian law, especially in Aruna Shanbaug and Common Cause.

Mixed as the United States is, individual states have authority to make decisions about end-of-life issues. The requirement of informed consent and constitutional protections of privacy rights are broadly accepted to justify passive euthanasia and refusal of treatment. Physician-assisted dying is legal in Oregon and Washington with safeguards in place. American law places great importance on autonomy and consent of the patient and has also established procedural safeguards for those who are unable to make their own decisions.

In the past, Germany had a history of being against euthanasia because of ethical issues that were caused by the misuse of it during the Nazis regime. Assisted dying was later recognized by German constitutional courts, however, under the principles of human dignity and autonomy. The German solution is an expression of the ongoing conflict between autonomy and life protection in constitutional democracies.

The legal approach is still rather conservative for India. Indian law today does not allow active euthanasia or assisted suicide and only permits passive euthanasia. Social, economic and institutional concerns were the reasons for the judiciary's "restrained" approach. The Supreme Court acknowledged that Indian society is different from the Western society in its attitude towards death, notions about family responsibility, infrastructure of healthcare, and economic disparities, etc. The Court thus stressed the need for procedural protections and judicial control to reduce the risk of misuses.

Future debates will continue to be influenced by technological advances in medicine. Developments in life support technology, AI, organ support systems and neurological treatments could lead to more and more ethical issues regarding medical futility and quality of life. These developments should continue to be reflected in constitutional jurisprudence, which must remain attuned to the basic principles of human dignity and compassion.

It thus appears that the constitutional morality and social realities need to be balanced in the making of the end-of-life decision in India in the future. Indian jurisprudence has already taken a progressive leap in recognizing that right to die with dignity is a part of Article 21. This right, however, can only be meaningfully realized if comprehensive healthcare reforms can be achieved, legal clarity can be obtained, ethical accountability can be introduced and societal dialogue can be encouraged. The development of passive euthanasia is but one example of the Constitution's ability to respond with compassion to human suffering while providing liberty, dignity, and justice in a democratic society.

7. Conclusion

Common Cause v Union of India is a landmark case in Indian constitutional and medical jurisprudence as it established the recognition of passive euthanasia in India. The judgment has essentially redefined the scope of Article 21 as a right to a dignified death under the appropriate and controlled conditions. The Supreme Court's decision to legalize passive euthanasia and to accept the notion of living wills brought constitutional ideals of autonomy, privacy, dignity and informed consent to the fore in decision-making for end-of-life issues.

Evolution of Judgments from Gian Kaur v State of Punjab to Common Cause illustrates the dynamic and progressive way of constitutional interpretation. Gradually, Indian constitutional law moved on from the narrow view of the sanctity of biological life to a more compassionate

perspective where dignity and freedom of choice are highlighted even in the later stages of life. The judgment recognized that a prolonged and futile medical treatment could be counterproductive to the values of the constitution.

Meanwhile, the acceptance of passive euthanasia gives rise to ongoing ethical, medical, human rights, and professional responsibility issues related to vulnerable people, health disparities, professional boundaries, and misuse. If effective implementation is to be achieved, there needs to be robust safeguards, building up awareness of the public and a better system of palliative care, as well as comprehensive legislative regulation. India is faced with the challenge of balancing compassion with prudence, and maintaining the dignity, equality and justice that should underpin the governance of healthcare.

Eventually, the transition in the constitution that began with Common Cause is a testament to a fundamental new appreciation that a dignified life is also a dignified death. It is a significant decision that reaffirms the concept of human autonomy, compassionate constitutionalism and progressive rights approach to healthcare jurisprudence in India.

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