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The Right to Die with Dignity: Making Advance Directives Work

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The Right to Die with Dignity: Making Advance Directives Work

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INTERVIEW ANGLE

"Should India simplify the advance directive procedure, and does personal autonomy over end-of-life decisions override the state's interest in preserving life?"

Seven years after the Supreme Court's landmark ruling in **Common Cause v. Union of India (2018)** recognised passive euthanasia and advance directives, the constitutional promise remains largely unrealised. The Court's return to this question in the **Harish Rana** case is an opportunity — and an obligation — to close the gap between the right as declared and the right as exercised.

The gap exists because the 2018 judgment, well-intentioned and constitutionally sound, erected a procedural fortress around the right that few can scale. A terminally ill patient wishing to execute a living will must navigate a two-medical-board review and obtain a judicial magistrate's countersignature — a process so cumbersome that in seven years of implementation, it has effectively not been used. A right that cannot be exercised is no right at all.

THE CONSTITUTIONAL FOUNDATION

The Court's 2018 reasoning was impeccable. Article 21 has, through decades of expansive interpretation, been understood to protect not merely the fact of life but its *quality* — its dignity. The right to refuse extraordinary medical intervention when facing terminal illness is simply the inverse of the right to medical treatment: both derive from bodily autonomy. A human being is not constitutionally reducible to a biological machine that must be kept running regardless of their wishes or suffering.

The **advance directive** — the legal mechanism through which an individual records their end-of-life wishes while still competent — is the instrument through which this right is exercised prospectively. Its legal validity was affirmed. Its practical uselessness was simultaneously constructed.

WHY THE PROCEDURE FAILED

The 2018 guidelines required:

The patient to execute the advance directive in writing

Two witnesses to be present

Attestation before a **judicial magistrate** (not a notary, not a doctor — a judicial magistrate, an officer of the criminal courts)

If the directive was ever to be acted upon, a **first medical board of two doctors** at the treating hospital must assess

A **second medical board** constituted by the Chief Medical Officer of the district must also review

Only after both boards concur may treatment be withdrawn

Each step involves a different institution: a court, a hospital, a district health authority. Each institution has different timelines, incentives, and risk tolerances. A judicial magistrate who countersigns a living will is unlikely to do so without consulting higher authority — the risk of being named in a future complaint is a genuine professional deterrent. Hospital medical boards, conscious of potential liability, default to prolonging treatment rather than withdrawing it.

The result: **palliation over autonomy**. Patients who have clearly expressed, in writing, that they do not wish to be kept on life support in a terminal condition die on life support — not because the law forbids otherwise, but because the mechanism to implement their wishes is dysfunctional.

SIMPLIFICATION — WHAT THE COURT COULD DO

The January 2026 hearings suggest the Court is considering several modifications:

Remove the Judicial Magistrate Requirement

The magistrate's role was presumably to add solemnity and prevent abuse. But a notarised document — executed before a notary public or even a gazetted officer — achieves the same authentication without requiring access to a court. For illiterate or semi-literate patients in rural areas, accessing a judicial magistrate is an insurmountable barrier. A notarisation requirement would be sufficient.

Single Medical Board

The dual-board requirement creates redundancy and delay — the very moment when a patient is in extremis and their family is seeking to honour their wishes. A single, multi-disciplinary hospital medical board — including a physician specialising in the patient's condition, a neurologist or geriatrician as appropriate, and a palliative care specialist — can make a defensible clinical determination. The CMO-level second board adds bureaucracy without clinical value.

Advance Directive Registry

A **national digital registry** — analogous to organ donor registries — would allow citizens to register their advance directives electronically, accessible to treating physicians at the point of care. This removes the problem of the document being unavailable when needed. The Ministry of Health and Family Welfare could create and maintain such a registry under the National Digital Health Mission (NDHM/Ayushman Bharat Digital Mission) framework.

Video Witnessing

The Court may allow advance directives to be witnessed by video — with timestamped recordings stored in the registry — to address the challenge of finding two physical witnesses in rural or socially isolated settings.

THE ETHICAL OBJECTIONS — ADDRESSED

The Slippery Slope

Critics argue that simplifying advance directives will lead inevitably to active euthanasia. This is empirically contestable. The Netherlands and Belgium have had legalised euthanasia for over two decades without evidence of the "slippery slope" into involuntary euthanasia at scale. The slope is not inherent to the policy; it is prevented by robust implementation, medical ethics training, and judicial oversight.

More importantly, India is not moving toward active euthanasia. The Harish Rana proceedings are narrowly about making the *existing* passive euthanasia framework functional — not about extending it. A clear legislative framework, if eventually enacted by Parliament, would provide greater certainty than repeated judicial improvisation.

The Vulnerability of the Elderly

A legitimate concern is that simplified procedures could be abused by families seeking to withdraw treatment for financial reasons rather than the patient's expressed wish. This concern argues for *better* safeguards, not *more burdensome* ones. Specifically:

> The advance directive must reflect the **patient's own wishes**, not a family consensus
>
> A treating physician's certification that the directive is voluntary and informed should be mandatory
>
> The directive should be **revocable at any time** while the patient has capacity — a provision already in the 2018 guidelines

The Sanctity of Life Argument

Some religious traditions hold that life is sacred and must be preserved regardless of suffering. This is a legitimate moral position. But constitutional law in a secular republic must accommodate religious diversity by not imposing any single tradition's view of life's sanctity on all citizens. A citizen who holds that life must be

preserved until natural death is free not to execute an advance directive. They should not have the power — through a dysfunctional procedure — to prevent others from exercising the opposite choice.

BEYOND THE PROCEDURE: THE PALLIATIVE CARE GAP

Any discussion of passive euthanasia in India must confront a prior failure: the near-absence of **palliative care**. India has approximately **0.5 palliative care specialists per 100,000 people** — compared to 60 in Australia. For most Indians facing terminal illness, the choice is not between a ventilator and a peaceful death; it is between aggressive, futile treatment in a government hospital and dying at home without adequate pain management.

The advance directive, important as it is, addresses only one end of the spectrum. The other end — ensuring that dying with dignity includes freedom from pain and access to hospice-level care — requires a separate policy push: mandatory palliative care training in medical colleges, inclusion of opioids in essential medicines lists at the district level (still inconsistently implemented), and community-based palliative care programmes.

Kerala's Community-Based Palliative Care Model — pioneered from Kozhikode and now expanded state-wide — is a genuine success story that the Centre and other states should scale.

A PARLIAMENT-STATUTE WOULD BE BETTER

The Supreme Court has, commendably, stepped into the vacuum left by legislative inaction. But judicial guidelines are an imperfect substitute for parliamentary legislation. The legal framework for advance directives deserves a **dedicated parliamentary statute** — one that can define eligibility criteria, establish the registry, set out the medical board process, specify criminal penalties for forged or coerced directives, and provide immunity protection for physicians who act in good faith on a valid directive.

The **Draft Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations** touched on this, but incompletely. A standalone Advance Directive Act — modelled on comparable legislation in Canada, Australia, and the UK — would provide the clarity that both patients and physicians need.

Until Parliament acts, the Court must ensure that the constitutional right it has recognised does not remain a parchment promise. The Harish Rana proceedings offer that opportunity. A simplified, accessible, and digitally-enabled advance directive procedure — combined with serious investment in palliative care — would be a meaningful step toward the right to die with dignity that the Constitution guarantees.

📌 FACTS CORNER — KNOWLEDGEPEDIA

PASSIVE EUTHANASIA LEGAL TIMELINE:

Aruna Shanbaug v. UoI (2011): first judicial recognition; High Court approval required

Common Cause v. UoI (2018): Article 21 includes right to die with dignity; advance directives valid

Harish Rana case (2026): seeking simplification of 2018 procedure

COMMON CAUSE 2018 — PROCEDURE (CRITICISED AS TOO COMPLEX):

- Patient executes written advance directive
- Two witnesses present
- Judicial magistrate must attest
- Hospital medical board of two doctors reviews when needed
- District CMO constitutes second medical board
- Both boards concur before treatment withdrawal

PROPOSED SIMPLIFICATIONS (2026):

Replace judicial magistrate with notary/gazetted officer

Single multi-disciplinary medical board (instead of two)

National digital registry (under ABDM framework)

Video witnessing provision

ARTICLE 21 — SCOPE:

Right to livelihood: Olga Tellis (1985)

Right to health: CESC Ltd (1996)

Right to privacy: Puttaswamy (2017)

Right to die with dignity: Common Cause (2018)

EUTHANASIA TYPES:

Passive: withdrawing treatment (legal in India, 2018)

Active: administering lethal agent (illegal in India)

Voluntary: patient has consented (advance directive)

Non-voluntary: patient incapacitated; medical/judicial decision

PALLIATIVE CARE IN INDIA:

India has ~0.5 palliative care specialists per 100,000 people

Kerala model: community-based palliative care from Kozhikode

Opioid access: inconsistently implemented at district level

Needs: palliative training in medical colleges; hospice infrastructure

OTHER RELEVANT FACTS:

Netherlands + Belgium: active euthanasia legal since 2002

Canada: Medical Assistance in Dying (MAID) since 2016

UK: passive euthanasia allowed; active illegal

Section 309 IPC: attempt to suicide; Mental Healthcare Act 2017 (Section 115) creates presumption of severe stress

> Ayushman Bharat Digital Mission (ABDM): national digital health infrastructure

Sources: Indian Express, The Hindu, Supreme Court of India

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