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THE RIGHT TO DIE - SHOULD IT BE MINE TO CHOOSE?

A CONSTITUTIONAL ANALYSIS UNDER INDIAN LAW

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ABSTRACT

This article examines the legal and constitutional dimensions of the right to die in India, with particular focus on the interplay between Article 21 of the Indian Constitution, the Bharatiya Nyaya Sanhita, 2023 (BNS), the Mental Healthcare Act, 2017, and evolving judicial doctrine. The right to die — encompassing passive euthanasia and the execution of advance medical directives — has long occupied an uncertain position in Indian law. *Gian Kaur v. State of Punjab* (1996) firmly denied any constitutional recognition of a right to die, grounding its analysis in the sanctity of life. Subsequent developments in *Aruna Ramchandra Shanbaug v. Union of India* (2011) and *Common Cause (A Regd. Society) v. Union of India* (2018) marked a significant doctrinal shift, recognizing that the right to live with dignity under Article 21 necessarily extends to the right to die with dignity in cases of terminal illness or permanent vegetative state.

The article critically evaluates the persistent tension between judicial recognition and statutory silence. While the Supreme Court has established procedural safeguards for passive euthanasia and living wills, the BNS continues to criminalize attempted suicide (Section 224) and abetment of suicide (Section 107), generating a fragmented legal landscape. The Mental Healthcare Act, 2017 partially bridges this gap by presuming that suicide attempts arise from severe stress rather than criminal intent, yet a comprehensive legislative framework governing end-of-life decisions remains absent. Through a comparative analysis of international jurisprudence — including *Pretty v. United Kingdom* (ECHR, 2002), *Carter v. Canada* (2015), and Dutch and Belgian euthanasia legislation — this article argues that India's current framework, though constitutionally progressive, is operationally deficient. The article concludes with normative recommendations for legislative codification, institutional safeguards, and medical guidelines to ensure that the right to die with dignity is meaningful, equitable, and protective of vulnerable populations.

Keywords: Right to Die, Article 21, Passive Euthanasia, Advance Directives, Bharatiya Nyaya Sanhita, Mental Healthcare Act, Constitutional Morality, Dignity, Autonomy, End-of-Life Law.

CHAPTER 1: INTRODUCTION

The issue of the "right to die" has long been a cause of intense debate in law, philosophy, medicine, and public policy. Central to it is the fundamental question: does the constitutional promise of the right to life under Article 21 of the Indian Constitution include the right to die with dignity? This question has taken on growing urgency in contemporary times, as medical technology has advanced rapidly, extending life but also making it possible for persons to be kept alive in a biological sense

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alone, without mental or physical independence.

This issue has been played out in India through a nuanced interplay between constitutional interpretation, criminal law under the Bharatiya Nyaya Sanhita (BNS), and judicially developed protection for euthanasia and advance directives. The Supreme Court in

Earlier, the Supreme Court in *Gian Kaur v. State of Punjab* (1996) unequivocally disapproved any constitutional acknowledgment of a right to die, underscoring the sanctity of life.[1] Later judgments — *Aruna Shanbaug v. Union of India* (2011) and *Common Cause v. Union of India* (2018) — indicated a decisive change by legally accepting passive euthanasia and advance medical directives, bringing to the fore the principles of autonomy and dignity.[2]

This research paper places the "right to die" controversy in the backdrop of India's statutory and constitutional law, specifically examining the interaction between Article 21, Sections 224 and 107 of the BNS, the Mental Healthcare Act, 2017, and the changing judicial approach. In doing so, it seeks to examine whether the Indian legal system adequately balances the individual's autonomy and dignity against the State's responsibility to protect life, and whether the recognition of passive euthanasia constitutes an incremental step towards a fuller acknowledgment of end-of-life rights.

I. Statement of the Problem

The issue of fundamental concern is the inherent conflict between the sanctity of life as a constitutional principle and the claim of individual autonomy in choosing the mode and time of one's death.

The Indian Constitution ensures the right to life by Article 21, but says nothing directly about a right to die. Judicial interpretation — particularly in

Judicial interpretation — particularly in *Gian Kaur v. State of Punjab* — has excluded suicide and assisted dying from the scope of Article 21. However, later case law, more specifically *Common Cause v. Union of India*, has gingerly broadened this space by recognizing the right to withhold medical treatment, allowing passive euthanasia and living wills under strict conditions.[3] This results in a complicated paradox.

On one side, Sections 224 and 107 of the Bharatiya Nyaya Sanhita still criminalize attempted suicide and abetment of suicide. On the other side, the Mental Healthcare Act, 2017 softens this criminalization by presuming that persons attempting suicide are under extreme stress and hence not punishable. The Supreme Court has provided guidelines that allow patients to withhold life-sustaining treatment, thereby permitting withdrawal of life support in some cases. This double-track creates a fragmented legal system in which patient autonomy over death remains conditional, vague, and highly controlled.

The study will specifically examine:

(i) Whether the establishment of passive euthanasia and advance directives in *Common Cause* sufficiently protects autonomy without creating scope for abuse;

(ii) The effect of the provisions of the Bharatiya Nyaya Sanhita on attempted suicide and abetment in the context of constitutional evolution;

(iii) The theoretical rationales — dignity, autonomy, and state interest in preserving life — that underpin judicial logic; and

(iv) The practical obstacles to implementing end-of-life decisions within the existing statutory and regulatory regime.

II. Research Objectives

(1) To examine the constitutional foundation of the right to die under Articles 21, 14, and 19 of the Indian Constitution.

(2) To assess the influence of legislative provisions — namely Sections 224

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and 107 of the BNS and Section 115 of the Mental Healthcare Act, 2017 — on the regulation of suicide and euthanasia.

(3) To critically evaluate judicial precedents including *Gian Kaur* (1996), *Aruna Shanbaug* (2011), and *Common Cause* (2018), to trace the trajectory of Indian jurisprudence on the right to die.

(4) To evaluate the sufficiency of Supreme Court guidelines on passive euthanasia and living wills, and the challenges in their implementation.

(5) To compare the Indian approach against international constitutional precedents (e.g., U.S. and European rulings) to identify models for balancing autonomy and state interest.

(6) To provide normative suggestions as to whether and under what circumstances the right to die should be expressly enshrined in India's constitutional or statutory law, and what measures are needed to prevent misuse.

III. Research Questions

Does the constitutional promise of the right to life under Article 21 also include a legally recognized right to die with dignity, and how adequately do the Bharatiya Nyaya Sanhita, the Mental Healthcare Act, and judicial precedents balance individual autonomy with the State's responsibility to maintain life?

IV. Significance of Research

The right to die issue is one of the most intricate convergences of law, ethics, medicine, and human rights. In India, the matter has emerged prominently through judicial decisions, including *Common Cause v. Union of India* (2018), which legalized passive euthanasia and advance directives under Article 21.[4] The importance of this study lies in its contribution to three crucial fields: constitutional jurisprudence; legal policy; and societal impact.

V. Scope and Limitations

The study is centered on: (i) doctrinal examination of judicial precedents, specifically the three landmark cases above; (ii) statutory examination of the BNS, 2023, and the Mental Healthcare Act, 2017; (iii) secondary academic literature; and (iv) comparative insights from global jurisprudence, including Dutch euthanasia legislation and European Court of Human Rights decisions.

The research is limited to passive euthanasia and the legal recognition of living wills and does not extend to active euthanasia, which is legislatively prohibited in India. The analysis is primarily doctrinal and qualitative rather than empirical, and comparative analysis is descriptive rather than exhaustive.

VI. Research Methodology

The research follows a doctrinal research approach, drawing on primary and secondary legal sources. Primary sources include constitutional provisions (Article 21), statutes (the BNS, 2023, and the Mental Healthcare Act, 2017), and judicial decisions. Secondary sources include academic journals (SCOPUS, JSTOR, Web of Science), established legal textbooks and encyclopedias, and comparative legislative materials. The analytical approach is qualitative and interpretative, employing jurisprudential principles — dignity, autonomy, and constitutional morality — to evaluate judicial reasoning.

CHAPTER 2: LITERATURE REVIEW — PRIMARY AND SECONDARY SOURCES

I. Constitutional Provisions

A. Article 21 — Protection of Life and Personal Liberty

Article 21 provides that "[n]o person shall be deprived of his life or personal liberty except according to procedure established by law." In *Gian Kaur v. State of Punjab*, the Supreme Court reaffirmed that the "right to life" does not mean a "right to die."[5] However, in *Common Cause v.*

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Union of India, Article 21 was construed to embrace the right to die with dignity in specific circumstances — namely through passive euthanasia and the enforcement of advance directives.[6]

B. Article 14 — Equality Before Law

Article 14 has been invoked in arguments about end-of-life decisions to challenge discriminatory treatment between patients who are able or unable to exercise autonomy — for example, as between patients in a vegetative state and those who are terminally ill but conscious.

C. Article 19(1)(a) — Freedom of Speech and Expression

Article 19(1)(a) has occasionally been invoked to encompass a person's expression of end-of-life wishes through living wills. The Court in Common Cause recognized that the expression of medical treatment preferences is a protected form of communication.

II. Statutory Provisions — Bharatiya Nyaya Sanhita, 2023 (BNS)

A. Section 224 — Attempt to Commit Suicide

Section 224 of the BNS penalizes an attempt at suicide, mirroring the erstwhile Section 309 of the Indian Penal Code, 1860 (IPC).[7] The Mental Healthcare Act, 2017 (Section 115) significantly curtails prosecution by raising a presumption of extreme stress — however, the BNS provision technically remains in force unless the presumption under the MHCA applies.

B. Section 107 — Abetment of Suicide

Section 107 punishes abetment of suicide with greater severity when directed against vulnerable persons. It is relevant to the right-to-die discourse because active euthanasia or assisted suicide may be prosecuted as abetment, effectively foreclosing a legislative pathway for assisted dying.

III. Other Relevant Statutes

A. Mental Healthcare Act, 2017 (MHCA)

Section 115 of the MHCA provides that "any person who attempts to commit suicide shall be presumed, unless proved otherwise, to have severe stress and shall not be tried and punished" under the relevant code.[8] This represents a pragmatic relaxation of the BNS's punitive framework, though it does not achieve complete decriminalization. The Act also emphasizes patient autonomy in mental health treatment decisions.

B. Transplantation of Human Organs and Tissues Act, 1994

Though not specifically governing the right to die, this Act permits the removal of organs after death, intersecting with certain end-of-life care considerations.

IV. Rules and Regulatory Framework

A. Supreme Court Guidelines on Passive Euthanasia and Advance Directives

The guidelines established in *Common Cause* (2018), and subsequently simplified in 2023, provide comprehensive procedures for preparing, signing, and executing a living will. Two medical boards — primary and secondary — are required to authenticate the patient's condition and the genuineness of the directive. In 2023, the Court eased certain procedural conditions, including the waiver of the magistrate countersignature requirement.[9]

V. Primary Sources — Landmark Judgments

A. Gian Kaur v. State of Punjab, (1996) 2 SCC 648

In *Gian Kaur*, the Supreme Court considered whether the constitutional right to life encompasses a right to die, and whether penal provisions criminalizing attempted suicide and its abetment are constitutionally valid. The Court ruled that Article 21 does not confer a right to die, emphasizing the sanctity of life and rejecting the concept of a constitutional freedom to terminate one's existence, even if

framed as individual autonomy.[9] The case remains the doctrinal starting point for any examination of the right to die in India.

B. Aruna Ramchandra Shanbaug v. Union of India, (2011) 4 SCC 454

In *Aruna Shanbaug*, a petition was filed seeking withdrawal of life support for a patient who had been in a permanent vegetative state for over three decades. The Court dismissed the specific petition but, for the first time, permitted passive euthanasia under judicial oversight.[11] While active euthanasia remains prohibited, the decision established the principle that the State's interest in preserving life must be weighed against the futility of prolonging suffering, and that passive withdrawal of treatment may be permissible under stringent safeguards.

C. Common Cause (A Regd. Society) v. Union of India, (2018) 5 SCC 1

In *Common Cause*, a five-judge constitutional bench delivered a landmark judgment affirming that the right to live with dignity under Article 21 encompasses the right to die with dignity.[12] The Court declared living wills and advance medical directives constitutionally valid, relying upon the right to privacy recognized in *K.S. Puttaswamy v. Union of India* (2017). The judgment established that compelling a person to undergo invasive treatment against their expressed wishes infringes upon constitutional dignity. Detailed guidelines were issued for the execution and enforcement of advance directives.

CHAPTER 3: ANALYSIS

I. Conceptual Framework — Autonomy, Dignity, and the Right to Die

The debate about the right to die is where law, ethics, and human dignity intersect. At its core, it poses the question of whether the State, even as devoted to the preservation of life, can acknowledge a person's autonomy in opting for death over prolonged suffering. The jurisprudence on this subject is deeply informed by competing ideas about liberty, morality, and the role of law in regulating life and death.

A. Autonomy and Dignity as Core Principles

Autonomy — the ability of individuals to exercise free and informed choices regarding their own lives — enshrines the concept of self-determination underpinning liberal democratic theory since John Stuart Mill's *On Liberty*. Mill argued that the individual is sovereign over their own body and mind, and the State has no authority to intrude except where such acts harm others.[13]

Dignity, in the Kantian tradition, holds that human beings must always be treated as ends rather than means.[14] Applied to end-of-life decisions, dignity indicates that compelled endurance of unendurable suffering or total loss of bodily control may itself constitute an affront to human dignity. This was articulated by Justice D.Y. Chandrachud in *Common Cause v. Union of India* (2018), who observed that "the right to live with dignity also includes the right to die with dignity."[15]

B. Natural Law Arguments

The natural law tradition, drawing on scholars such as Thomas Aquinas, holds that life is divinely conferred and therefore inviolable.[16] Suicide and euthanasia are inherently impermissible as they contradict the natural inclination toward self-preservation. Indian society, rooted in its religious heritage, has historically been sympathetic to this view.

C. Utilitarian Arguments

Conversely, utilitarian theory evaluates actions by their consequences, with the aim of maximizing aggregate welfare and minimizing pain. Under utilitarian analysis, maintaining a terminally ill patient alive in unrelenting agony may produce no good utility, while permitting a dignified death may reduce suffering for both the patient and the family. This perspective has significantly influenced permissive euthanasia regimes in the Netherlands, Belgium, and Canada.

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D. Constitutional Morality

In India, the doctrine of constitutional morality — requiring allegiance to constitutional values even when they conflict with prevailing social morality — has increasingly influenced judicial reasoning. In *Navtej Singh Johar v. Union of India* (2018), the Supreme Court invoked constitutional morality to uphold individual autonomy against societal prejudice.[17] The same logic supports recognition of the right to die as a dimension of the right to live with dignity.

II. Development of the Right to Die in Indian Jurisprudence

A. Early Resistance: Gian Kaur (1996)

In *Gian Kaur*, the Court held that the "right to life is inherently inconsistent with the right to die," underscoring that Article 21 protects life, not its destruction.[18] The decision was grounded in the natural law principle of sanctity of life. Yet the Court drew a thin distinction between suicide and the withdrawal of life-saving treatment for the terminally ill, leaving a narrow window for future development.

B. Acceptance of Passive Euthanasia: Aruna Shanbaug (2011)

The Court in *Aruna Shanbaug* introduced the principle of proportionality into end-of-life discourse: the State's interest in preserving life must be weighed against the futility of extending suffering.[19] The Court distinguished passive euthanasia — withdrawal of life support — from active euthanasia, which remains prohibited, paving the way for more nuanced jurisprudence.

C. Constitutional Consolidation: Common Cause (2018)

In *Common Cause*, the Court declared that the right to live with dignity under Article 21 encompasses the right to die with dignity. Relying on the right to privacy recognized in *K.S. Puttaswamy v. Union of India* (2017), the Court held that compelling a person to undergo invasive treatment against their will constitutes a violation of dignity. Living wills and advance medical directives were declared legally valid, subject to procedural safeguards.[20]

III. Statutory and Constitutional Framework

A. Article 21 and Its Interpretation

Originally interpreted narrowly in *A.K. Gopalan v. State of Madras* (1950), Article 21 was subsequently expanded in *Maneka Gandhi v. Union of India* (1978) to incorporate substantive due process.[21] In *Common Cause*, the Court categorically stated that dignity is inseparable from life — the right to life cannot be understood as mere animal existence but encompasses the right to decide the mode of one's death in cases of terminal illness or permanent vegetative state.

B. The Bharatiya Nyaya Sanhita, 2023 (BNS)

The BNS, which supersedes the IPC, retains provisions relevant to the right to die. Section 224 replicates erstwhile Section 309 IPC, criminalizing attempted suicide, albeit with reduced practical effect after the MHCA. Section 225 continues to criminalize abetment of suicide. The BNS does not specifically provide for euthanasia or assisted dying, creating a legislative vacuum bridged only by judicial guidelines. This legislative silence generates significant uncertainty: physicians and hospitals are reluctant to act on advance directives for fear of criminal prosecution.

C. The Mental Healthcare Act, 2017

Section 115 of the MHCA provides that any person who attempts suicide shall be presumed, unless proved otherwise, to have severe stress and shall not be tried or punished. This provision reflects an international trend treating suicide as a public health matter rather than a criminal act. However, the MHCA does not speak to euthanasia or assisted dying; its focus is treatment and rehabilitation rather than end-of-life autonomy.

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IV. Comparative Perspectives

A. Pretty v. United Kingdom (ECHR, 2002)

In *Pretty v. United Kingdom*, the European Court of Human Rights held that Article 2 of the European Convention on Human Rights — the right to life — does not entail a right to die.[22] However, the Court acknowledged the tension between state interests and personal autonomy, leaving the matter to national legislatures. The ruling fuelled policy debates resulting in more liberal frameworks in some European jurisdictions.

B. Carter v. Canada (2015)

In *Carter v. Canada (Attorney General)*, the Supreme Court of Canada struck down the prohibition on physician-assisted dying, finding it violated the rights to life, liberty, and security under the Canadian Charter.[23] The Court found that requiring terminally ill patients to endure intolerable suffering, or to seek early deaths while still physically capable, robbed them of dignity. This judgment prompted enactment of legislation governing Medical Assistance in Dying (MAID) under stringent safeguards, offering a model for balancing autonomy with protection against abuse.

C. Dutch and Belgian Models

The Netherlands became the first jurisdiction to legalize euthanasia through the Termination of Life on Request and Assisted Suicide Act, 2002.[24] Belgium followed shortly thereafter. These models are frequently invoked as benchmarks for institutionalizing protective mechanisms while respecting individual autonomy. Critics, however, note that over time eligibility criteria have progressively broadened — covering, in some cases, psychiatric patients and children — raising concerns about incremental erosion of safeguards.

D. Cultural, Ethical, and Religious Differences

Comparative analysis reveals that euthanasia legislation is highly influenced by cultural and religious context. In secular jurisdictions with strong individual rights traditions, autonomy predominates. In culturally and religiously diverse societies such as India, sanctity-of-life arguments carry greater weight. India's pluralistic religious landscape — Hindu, Islamic, and Christian value systems, each traditionally opposed to euthanasia — alongside socio-economic inequalities and fears of elder abuse, renders direct adoption of permissive euthanasia models inadvisable. Any Indian legislative framework must be tailored to these specific realities.

V. Practical Challenges and Critiques

A. Implementation Challenges

India's medical infrastructure remains incapable of implementing the complex procedures specified in Common Cause. The requirement of primary and secondary medical boards, judicial oversight, and detailed documentation is burdensome in an already resource-constrained system. In rural areas where even basic healthcare is inaccessible, end-of-life rights exist on paper alone.

B. Risks of Abuse

In a society marked by economic inequality and disregard for the elderly, recognition of the right to die carries risks of abuse. Families burdened by the cost of medical care may pressure elderly or terminally ill relatives into consenting to euthanasia. Women and other marginalized groups, who disproportionately lack autonomous decision-making power, are particularly vulnerable. Without robust oversight mechanisms, these dangers are significant.

C. Ethical Tensions in Medical Practice

Physicians face competing obligations: the Hippocratic commitment to preservation of life, and the imperative to respect patient autonomy. Navigating these obligations is morally complex, particularly in cultures where medical paternalism persists. The right to die also raises broader philosophical questions regarding the limits of autonomy and the State's responsibility to protect life — dilemmas

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that underscore the complexity of legislating death.

CHAPTER 4: FINDINGS

The research discloses the following principal findings:

First, the Indian judiciary — in the absence of comprehensive legislation — has been the primary driver of recognizing the right to die with dignity, but this has generated legal uncertainty in the absence of statutory codification.

Second, there has been a consistent judicial expansion of Article 21 from the right to biological life to encompass quality of life, dignity, and ultimately, dignified death — a trajectory demonstrating progressive constitutional morality.

Third, statutory inconsistencies persist: the BNS continues to criminalize attempted suicide and abetment, while the MHCA partially decriminalizes the former and the Constitution has been interpreted to permit passive euthanasia — creating a fragmented and sometimes contradictory legal landscape.

Fourth, advance directives and passive euthanasia, though constitutionally recognized, are rarely invoked in practice owing to inadequate medical training, bureaucratic obstacles, and low public awareness.

Fifth, jurisdictions such as the Netherlands, Belgium, and Canada have enacted clear legislation governing euthanasia and assisted dying, while India's reliance on judicial guidelines generates inconsistency and unpredictability.

CHAPTER 5: SUGGESTIONS AND CONCLUSION

I. Suggestions

1. Legislative Codification: Parliament should enact comprehensive legislation governing passive euthanasia and advance directives, incorporating mechanisms to guard against coercion, undue influence, and abuse.

2. Medical Guidelines: The Medical Council of India and the Ministry of Health should issue binding guidelines for training medical professionals in end-of-life care and the execution of advance directives.

3. Awareness Programs: Government and civil society should initiate public awareness campaigns to educate citizens regarding their rights under Common Cause and the Mental Healthcare Act.

4. Independent Review Boards: Independent oversight bodies should be established to review euthanasia requests, ensuring transparency, accountability, and protection of vulnerable populations.

5. Comparative Adaptation: Elements of the Dutch and Canadian models should be studied and selectively adapted, with necessary modifications to reflect India's socio-cultural and religious context.

II. Conclusion

India's right to die, though judicially recognized, stands at a stage of partial realization. The courts have progressively widened the canvas of Article 21, but in the absence of legislative codification, implementation remains uncertain. This study affirms that a dignified death cannot be separated from the right to live with dignity — the constitutional assurance of life must necessarily encompass autonomy at its natural end.

Going forward, the challenge is to balance respect for personal choice with protection against exploitation. Well-crafted legislation, accompanied by medical and social reform, can ensure that the right to die is exercised responsibly, ethically, and in accordance with India's constitutional ethos.

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