EXPANDING SCOPE OF ARTICLE 21: FROM RIGHT TO LIFE TO RIGHT TO DIE: A CRITICAL EXAMINATION OF INDIAN CONSTITUTIONAL LAW

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ABSTRACT

Article 21 of the Indian Constitution, which protects the right to life and personal liberty, has been expansively interpreted by the Supreme Court to include the right to live with human dignity. This paper critically examines the evolution of Article 21 from safeguarding mere existence to encompassing the "right to die with dignity" through passive euthanasia and Advance Medical Directives. It traces the significant judicial trajectory from the categorical rejection of the right to die in *Gian Kaur v. State of Punjab* (1996), through the landmark decisions in *Aruna Ramchandra Shanbaug v. Union of India* (2011) and *Common Cause (A Regd. Society) v. Union of India* (2018), the modification of guidelines in 2023, to the recent application in *Harish Rana v. Union of India* (2026). The study analyses the constitutional foundations rooted in dignity, autonomy, and privacy, while critically evaluating the ethical dilemmas, risks of misuse, slippery-slope concerns, and the persistent legislative vacuum. A comparative analysis with jurisdictions such as the United Kingdom, United States, Netherlands, and Canada highlights India's cautious, judicially-driven approach. The paper argues that while the Supreme Court's transformative constitutionalism has advanced individual autonomy in end-of-life decisions, comprehensive legislation is essential to provide clarity, robust safeguards, and uniform implementation across the country.

Keywords: Article 21, Right to Die with Dignity, Passive Euthanasia, Advance Medical Directives, Living Wills, Transformative Constitutionalism, Judicial Activism, End-of-Life Care, Indian Constitutional Law

Introduction

Article 21 of the Indian Constitution provides: "No person shall be deprived of his life or personal liberty except according to procedure established by law."[1] This seemingly simple guarantee has become the cornerstone of India's expansive constitutional jurisprudence on fundamental rights. Initially construed in a narrow, positivist manner as a safeguard against arbitrary executive deprivation, Article 21 underwent a transformative reinterpretation in the late 1970s, evolving into a dynamic repository of unenumerated rights that embody substantive due process, reasonableness, and, most crucially, human dignity.[2]

The Supreme Court's progressive expansion of "life" under Article 21 has encompassed a broad spectrum of dignitarian interests, including the right to privacy, a clean environment, livelihood, health, education, and shelter.[3] This doctrinal shift reflects the Court's commitment to transformative constitutionalism, adapting an 1950s-era text to the evolving socio-economic and ethical demands of a modern democracy. Among the most profound—and contentious—extensions of Article 21 is the recognition of a "right to die with dignity," which encompasses the ability to refuse life-sustaining medical treatment in terminal or irreversible conditions. This development pits the State's traditional interest in the preservation of life against core constitutional values of individual autonomy, bodily integrity, and personal liberty.[4]

This paper critically examines the judicial trajectory from a categorical rejection of any "right to die" to the affirmative recognition of passive euthanasia and advance medical directives. It evaluates whether the Supreme Court has appropriately balanced autonomy and safeguards or encroached upon the legislative domain. While judicial innovation has advanced personal dignity in end-of-life decisions, the persistent absence of comprehensive legislation continues to generate procedural uncertainty and implementation challenges. A comparative perspective further illuminates India's cautious, judge-led approach within the global discourse on assisted dying.

I. Historical and Doctrinal Evolution of Article 21

The early jurisprudence on Article 21 adopted a strictly procedural lens, insulating executive

[1] INDIA CONST. art. 21.
[2] *A.K. Gopalan v. State of Madras*, AIR 1950 SC 27 (India).
[3] *Maneka Gandhi v. Union of India*, (1978) 1 SCC 248 (India).
[4] *See generally Justice K.S. Puttaswamy (Retd.) v. Union of India*, (2017) 10 SCC 1 (India) (discussing autonomy and dignity as facets of Article 21).

action from substantive judicial scrutiny. In *A.K. Gopalan v. State of Madras*, the Supreme Court held that Article 21 required only compliance with enacted law, without importing principles of natural justice or reasonableness from Articles 14 or 19.[5] This "procedure established by law" doctrine insulated preventive detention laws from broader constitutional challenge and confined "life" to mere physical existence.[6]

The landmark decision in *Maneka Gandhi v. Union of India* marked a paradigmatic shift. Overruling the *Gopalan* majority's compartmentalized approach, a seven-judge bench held that any procedure depriving life or personal liberty must be "just, fair and reasonable" and must satisfy the tests of Articles 14 and 19.[7] By reading the three articles as forming a "golden triangle," the Court infused Article 21 with substantive due process, transforming it from a shield against executive excess into a powerful instrument for enforcing human dignity.[8] The judgment explicitly rejected the view that Article 21 merely replicated the English doctrine of parliamentary supremacy; instead, it aligned Indian constitutionalism with evolving global standards of reasonableness and fairness.[9]

Subsequent decisions built upon this foundation by giving concrete content to the phrase "right to life." In *Francis Coralie Mullin v. Administrator, Union Territory of Delhi*, the Court emphatically declared that the right to life "includes the right to live with human dignity" and extends to all those aspects of life that make it "worth living."[10] Justice P.N. Bhagwati, writing for the bench, observed that dignity is the core of Article 21, encompassing not only bare survival but the right to basic necessities, freedom from degrading treatment, and opportunities for self-development.[11] This dignitarian interpretation opened the door to reading numerous socio-economic rights into Article 21, including the right to a clean environment,[12] education,[13] livelihood,[14] and health care.[15]

The doctrinal evolution reached its zenith in *Justice K.S. Puttaswamy (Retd.) v. Union of India*,

[5] *A.K. Gopalan v. State of Madras*, AIR 1950 SC 27 (India).
[6] *Id.* at 105–06 (Kania, C.J.).
[7] *Maneka Gandhi*, (1978) 1 SCC at 280 (Beg, C.J.).
[8] *Id.* at 284.
[9] *Id.* at 291–92.
[10] *Francis Coralie Mullin v. Administrator, Union Territory of Delhi*, (1981) 1 SCC 608, 619 (India).
[11] *Id.* at 618–19.
[12] *M.C. Mehta v. Union of India*, (1987) 4 SCC 463 (India).
[13] *Unni Krishnan, J.P. v. State of Andhra Pradesh*, (1993) 1 SCC 645 (India).
[14] *Olga Tellis v. Bombay Municipal Corpn.*, (1985) 3 SCC 545 (India).
[15] *Parmanand Katara v. Union of India*, (1989) 4 SCC 286 (India).

where a nine-judge bench unanimously held that the right to privacy is an intrinsic part of the right to life and personal liberty under Article 21.[16] The Court traced privacy's constitutional roots to the values of dignity, autonomy, and liberty, explicitly linking it to decisional autonomy in intimate choices.[17] *Puttaswamy* provided the critical doctrinal bridge for end-of-life rights: if privacy and bodily integrity protect an individual's right to make intimate medical decisions during life, they logically encompass the right to refuse life-prolonging treatment when continued existence ceases to be dignified.[18] These expansions collectively established that Article 21 protects not merely biological existence but a meaningful, autonomous, and dignified life—setting the stage for interpreting the refusal of futile medical intervention as an exercise of constitutional self-determination rather than a prohibited act of self-destruction.[19]

II. The Right to Die: Judicial Odyssey

The judicial journey concerning the "right to die" under Article 21 began with challenges to the constitutional validity of Section 309 of the Indian Penal Code, 1860, which criminalized attempt to commit suicide. In *Maruti Sripati Dubal v. State of Maharashtra*, the Bombay High Court held that the right to life under Article 21 includes the right not to live, thereby striking down Section 309 as violative of Articles 14 and 21.[20]

This view was initially endorsed by the Supreme Court in *P. Rathinam v. Union of India*, where a two-judge bench declared Section 309 unconstitutional, describing a suicide attempt as a "cry for help" rather than an offense.[21] However, this position was short-lived. A five-judge Constitution Bench in *Gian Kaur v. State of Punjab* overruled *Rathinam*, holding that Article 21 does not include the "right to die" or the "right to be killed."[22] The Court drew a crucial distinction between the right to live with human dignity (which is protected) and the right to die (which is not). It upheld the validity of Sections 306 and 309 IPC, observing that the right to life cannot be interpreted to include the right to extinguish life by unnatural means.[23] The Bench, however, left open the possibility of permitting euthanasia through legislation.

[16] *Justice K.S. Puttaswamy (Retd.)*, (2017) 10 SCC at 496–97 (Chandrachud, J.).
[17] *Id.* at 366–67.
[18] *Id.* at 498–500.
[19] *Id.* at 501
[20] *Maruti Sripati Dubal v. State of Maharashtra*, 1987 Cri LJ 743 (Bom.).
[21] *P. Rathinam v. Union of India*, (1994) 3 SCC 394 (India).
[22] *Gian Kaur v. State of Punjab*, (1996) 2 SCC 648 (India).
[23] *Id.* at 660–62.

The focus then shifted from suicide to medical euthanasia. In *Aruna Ramchandra Shanbaug v. Union of India*, while rejecting the petition for active euthanasia on behalf of Aruna Shanbaug—who had remained in a persistent vegetative state for nearly four decades following a brutal assault—the Supreme Court for the first time permitted passive euthanasia (withholding or withdrawal of life-sustaining treatment) in exceptional cases.[24] The Court laid down elaborate guidelines requiring High Court approval, opinion of a medical board, and involvement of the next-of-kin or "next friend." Active euthanasia remained prohibited.[25] This decision marked the first judicial recognition of passive euthanasia in India, albeit as a narrowly circumscribed exception rather than a broad right.

The law was decisively advanced in *Common Cause (A Regd. Society) v. Union of India*. A Constitution Bench of five judges unanimously declared that the "right to die with dignity" is a fundamental right under Article 21.[26] The Court legalized passive euthanasia and the execution of Advance Medical Directives (living wills), holding that a competent adult's autonomy to refuse life-prolonging treatment flows from the values of dignity, privacy, and bodily integrity. It partially overruled the procedural limitations of *Aruna Shanbaug* and prescribed detailed safeguards, including execution of living wills before a Judicial Magistrate and constitution of multiple medical boards.[27]

On 24 January 2023, the same Constitution Bench modified the 2018 guidelines to address practical difficulties in implementation.[28] Key reforms included allowing attestation by a notary or gazetted officer instead of a Judicial Magistrate, integration with the National Health Digital Record, reduction of the minimum doctor experience requirement from twenty to five years, and imposition of strict timelines for medical board opinions.

The framework received its first concrete judicial application in *Harish Rana v. Union of India*, decided on 11 March 2026.[29] In this case, the parents of a 32-year-old man who had remained in a persistent vegetative state for over thirteen years after an accident sought withdrawal of Clinically Assisted Nutrition and Hydration (CANH) administered through a PEG tube. A Division Bench applied the *Common Cause* guidelines "in full measure," holding that CANH

[24] *Aruna Ramchandra Shanbaug v. Union of India*, (2011) 4 SCC 454 (India).
[25] *Id.* at 500–03.
[26] *Common Cause (A Regd. Soc'y) v. Union of India*, (2018) 5 SCC 1 (India).
[27] *Id.* at 78–80 (Dipak Misra, C.J.).
[28] *Common Cause v. Union of India*, Order (Jan. 24, 2023) (India) (modifying 2018 guidelines).
[29] *Harish Rana v. Union of India*, 2026 INSC 222 (India Mar. 11, 2026).

constitutes medical treatment (not basic care) and that its withdrawal is a permissible omission respecting the patient's right to die with dignity. The Court clarified that the preferred nomenclature is "withholding or withdrawing life-sustaining treatment" rather than "passive euthanasia," mandated palliative care, and reiterated the urgent need for comprehensive legislation.[30]

III. Critical Analysis

The Supreme Court's expansion of Article 21 to include the right to die with dignity represents a high point of transformative constitutionalism, yet it has invited significant scholarly and ethical critique. On one hand, the recognition of autonomy in end-of-life decisions is a logical extension of the privacy and dignity jurisprudence crystallized in *Puttaswamy*.[31] By treating the refusal of life-sustaining treatment as an exercise of bodily integrity rather than suicide, the Court has reconciled the tension between sanctity of life and quality of life, aligning Indian law with global trends that prioritize individual self-determination.[32]

Critics, however, argue that the Court has engaged in judicial legislation. The categorical holding in *Gian Kaur* that Article 21 does not encompass the right to die was substantially diluted in *Common Cause* without expressly overruling the earlier decision on this point, raising questions of doctrinal consistency and textual fidelity.[33] By laying down detailed guidelines and recognizing living wills, the judiciary arguably encroached upon a deeply moral and policy-laden domain better suited for legislative deliberation, especially in a culturally diverse society like India.[34]

From an ethical standpoint, the autonomy-based approach conflicts with the sanctity-of-life principle deeply rooted in Indian cultural and religious traditions. Legitimate concerns persist regarding the potential for misuse, coercion of vulnerable patients (particularly the elderly, disabled, or economically disadvantaged), and the "slippery slope" leading from passive to active euthanasia or non-voluntary euthanasia.[35] While the distinction between passive and active euthanasia provides a bright-line safeguard, the boundary can blur in practice—as

[30] Id.
[31] *Justice K.S. Puttaswamy (Retd.) v. Union of India*, (2017) 10 SCC 1 (India).
[32] *Common Cause*, (2018) 5 SCC at 45.
[33] *Gian Kaur*, (1996) 2 SCC 648; *cf. Common Cause*, (2018) 5 SCC 1.
[34] *Aruna Shanbaug*, (2011) 4 SCC 454 at 510.
[35] Law Comm'n of India, Rep. No. 241, *Passive Euthanasia* (Aug. 2012).

illustrated by the *Harish Rana* clarification on CANH—raising questions about subjective assessments by medical boards and family pressure.[36]

A persistent criticism is the continuing legislative vacuum. Despite repeated judicial exhortations in *Aruna Shanbaug*, *Common Cause*, and *Harish Rana*, Parliament has not enacted a comprehensive statute on end-of-life care.[37] The existing guidelines, even after the 2023 modifications, remain procedurally cumbersome and inaccessible to large sections of the population, particularly in rural areas with limited healthcare infrastructure.[38] This leaves physicians, patients, and families in a state of uncertainty and exposes them to potential criminal liability under the Indian Penal Code. The Mental Healthcare Act, 2017, provides for advance directives in psychiatric treatment, but a uniform law governing general medical end-of-life decisions is still absent.[39]

On the positive side, the judicially evolved framework has provided much-needed clarity, empowered patient autonomy, and advanced human dignity in a culturally conservative society. The recognition of living wills and the operationalization of guidelines in *Harish Rana* mark meaningful progress. Yet the full realization of this right requires robust legislative backing, nationwide palliative care infrastructure, public awareness campaigns, and hospital ethics committees to ensure uniform, compassionate, and abuse-free implementation.

IV. Comparative Perspective

India's judicially evolved framework for passive euthanasia stands in marked contrast to more permissive regimes in several jurisdictions while sharing common ground with common-law traditions that emphasize the withdrawal of futile treatment. The United Kingdom, for instance, permits the withholding or withdrawal of life-sustaining treatment—including clinically assisted nutrition and hydration—under the doctrine of best interests, without classifying it as euthanasia. In the seminal decision of *Airedale NHS Trust v. Bland*, the House of Lords authorized the discontinuation of artificial feeding for a patient in a persistent vegetative state, holding that such an omission did not constitute an unlawful act and was consistent with the patient's best interests.[40] This approach, now codified under the Mental Capacity Act 2005,

[36] Harish Rana, 2026 INSC 222.
[37] *See Common Cause*, (2018) 5 SCC at 120–22; *Harish Rana*, 2026 INSC 222.
[38] *See generally* reports on implementation challenges following the 2023 guidelines.
[39] Mental Healthcare Act, 2017, § 5 (India)
[40] *Airedale NHS Tr. v. Bland*, [1993] AC 789 (HL) (U.K.).

closely parallels India's *Common Cause* guidelines as applied in *Harish Rana v. Union of India*, where the Supreme Court similarly clarified that withdrawal of CANH is a lawful omission rather than an affirmative act causing death.[41]

In the United States, active euthanasia remains illegal at the federal level, but passive euthanasia through refusal of treatment is constitutionally protected under the Due Process Clause, as affirmed in *Cruzan v. Director, Missouri Department of Health*.[42] Several states, beginning with Oregon's Death with Dignity Act of 1994, have legalized physician-assisted suicide (often termed "medical aid in dying") for terminally ill competent adults, subject to strict procedural safeguards including multiple physician certifications and waiting periods.[43] This state-level experimentation contrasts with India's uniform, albeit judicially driven, national framework that expressly prohibits active intervention.

By comparison, countries such as the Netherlands, Belgium, Canada, and Australia have moved beyond passive measures to authorize active voluntary euthanasia and physician-assisted dying. The Netherlands became the first nation to legalize active euthanasia and assisted suicide under the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002, requiring unbearable suffering, informed consent, and independent medical review; the law has since been extended to minors in limited cases.[44] Canada's Medical Assistance in Dying (MAiD) regime, enacted in 2016 and expanded in 2021, permits both euthanasia and assisted suicide for adults with grievous and irremediable medical conditions, even where natural death is not reasonably foreseeable.[45] Australia has adopted a state-based model, with all six states legalizing voluntary assisted dying for terminally ill patients since Victoria's pioneering legislation in 2019.[46]

India's cautious, judge-led approach—confining recognition to passive euthanasia while maintaining a firm legislative and judicial prohibition on active euthanasia—reflects its pluralistic cultural, religious, and socio-economic realities. Unlike the Netherlands or Canada, where parliamentary legislation preceded or accompanied judicial recognition, India has relied

[41] *Harish Rana v. Union of India*, 2026 INSC 222 (India Mar. 11, 2026).
[42] *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990).
[43] *See* Or. Rev. Stat. §§ 127.800–127.995 (2023) (Death with Dignity Act).
[44] Termination of Life on Request and Assisted Suicide (Review Procedures) Act, 2002 (Neth.).
[45] Criminal Code, R.S.C. 1985, c. C-46, §§ 241.1–241.4 (Can.) (as amended by An Act to Amend the Criminal Code (Medical Assistance in Dying), S.C. 2021, c. 2).
[46] *See, e.g.,* Voluntary Assisted Dying Act 2017 (Vic) (Austl.); Voluntary Assisted Dying Act 2019 (W. Austl.) (Austl.).

almost exclusively on the Supreme Court's interpretive power under Article 21. The *Harish Rana* decision (2026) brings India's practice closer to the UK and U.S. common-law models on futile care, yet the absence of a comprehensive statute leaves it lagging behind jurisdictions that have enacted detailed eligibility criteria, reporting requirements, and oversight mechanisms to prevent abuse.[47] This comparative lens underscores both the strengths of India's dignity-centric jurisprudence and the limitations of its continued reliance on case-by-case adjudication.

V. Way Forward and Suggestions

While the Supreme Court's transformative interpretation of Article 21 has successfully constitutionalized the right to die with dignity, the full realization of this right demands legislative intervention to provide clarity, uniformity, and robust safeguards. The persistent legislative vacuum, repeatedly highlighted in *Aruna Shanbaug*, *Common Cause*, and *Harish Rana*, undermines the very autonomy the Court sought to protect.[48]

The following concrete recommendations are submitted for consideration:

1. Parliament should enact a comprehensive "End-of-Life Care and Advance Medical Directives Act" that codifies the *Common Cause* guidelines (as modified in 2023), defines key terms such as "terminal illness," "persistent vegetative state," and "clinically assisted nutrition and hydration," and establishes standardized procedures for both competent and incompetent patients. The statute must incorporate mandatory palliative care consultation, protection against coercion, and immunity for physicians acting in good faith.[49]

2. The Union and State Governments must substantially strengthen palliative care infrastructure, particularly in public hospitals and rural areas, through dedicated funding, training programs for healthcare professionals, and integration of palliative

[47] *See generally* K.R. Anusree, *Exploring Euthanasia: A Comparative Legal Analysis of India's Constitutional Approach and Global Practices*, 14 J. Pharm. Med. Sci. 132 (2025).
[48] *Common Cause (A Regd. Soc'y) v. Union of India*, (2018) 5 SCC 1, ¶¶ 120–22 (India); *Harish Rana*, 2026 INSC 222.
[49] *Accord* Law Comm'n of India, Rep. No. 241, *Passive Euthanasia* (2012).

medicine into medical curricula.[50]

3. Hospital ethics committees should be mandated in all tertiary care institutions to provide initial, non-judicial review of withdrawal requests where family consensus and medical board agreement exist, thereby reducing the burden on overburdened High Courts.[51]

4. A nationwide public awareness campaign, utilizing digital platforms and community health workers, should be launched to educate citizens on the execution and registration of Advance Medical Directives, countering cultural taboos surrounding end-of-life planning.[52]

5. The Ministry of Health and Family Welfare should periodically review the operational efficacy of the guidelines in light of emerging medical technologies (such as AI-assisted prognosis) and empirical data on implementation, with a statutory mandate to submit biennial reports to Parliament.[53]

These measures would harmonize judicial innovation with democratic legitimacy, ensuring that the right to die with dignity neither compromises the right to live with dignity for vulnerable populations nor exposes medical professionals to unwarranted criminal liability. Until such legislation is enacted, the Supreme Court remains the primary guardian of this evolving constitutional right, but the ultimate responsibility for a coherent, compassionate, and culturally sensitive regime rests with the legislature.

Conclusion

The Supreme Court's interpretive journey under Article 21—from the firm rejection of any "right to die" in *Gian Kaur v. State of Punjab* to the landmark recognition of the "right to die with dignity" as a fundamental facet of the right to life in *Common Cause (A Regd. Society) v. Union of India*[55] and its practical operationalization in *Harish Rana v. Union of India*—exemplifies the transformative potential of Indian constitutionalism. What began as a narrow guarantee against arbitrary deprivation of life has evolved into a robust charter of human

[50] See Ministry of Health & Family Welfare, Govt. of India, National Programme for Palliative Care: Operational Guidelines (2023).
[51] *Harish Rana*, 2026 INSC 222
[52] *Common Cause v. Union of India*, Order (Jan. 24, 2023) (India)
[53] *Id.*

dignity, encompassing not only the right to live meaningfully but also the right to exit life with dignity when continued existence becomes mere biological persistence. By grounding passive euthanasia and advance medical directives in the values of autonomy, privacy, and bodily integrity articulated in *Puttaswamy*, the Court has reconciled the tension between the State's interest in preserving life and the individual's sovereign right to refuse futile medical intervention.

This expansion, while doctrinally bold and compassionately progressive, remains incomplete. The persistent legislative vacuum—despite repeated judicial exhortations in *Aruna Shanbaug*, *Common Cause*, and *Harish Rana*—continues to generate procedural uncertainty, uneven implementation, and potential exposure of medical professionals to criminal liability. The 2023 guideline modifications and the *Harish Rana* clarification on clinically assisted nutrition and hydration represent important refinements, yet they cannot substitute for a comprehensive statute that codifies safeguards, promotes palliative care infrastructure, and addresses the unique socio-cultural realities of a pluralistic society.

Ultimately, the judiciary has opened the constitutional door to a dignified death. It now falls upon Parliament to secure the pathway through enlightened legislation that balances individual autonomy with protection of the vulnerable, ensures uniform application across the country, and upholds the sanctity of both the right to live with dignity and the right to die with dignity. Until that legislative wisdom materializes, Article 21 will continue to serve as the living conscience of the Constitution, reminding us that true respect for life includes the compassionate recognition of its limits. In the final analysis, the right to die with dignity is not the antithesis of the right to life—it is its necessary and humane corollary in a constitutional order committed to human flourishing.

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