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BETWEEN LIFE AND LETTING GO: RETHINKING THE CONSTITUTIONAL PROMISE OF DIGNITY THROUGH END-OF-LIFE AUTONOMY AND DO-NOT-RESUSCITATE ORDERS IN INDIA

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I. INTRODUCTION: BETWEEN LIFE AND LETTING GO

Death is something that people have always seen as the end of a life. For a long time, the law did not have much to say about life and death because doctors did not have the power to change how people die. A doctor could help with pain, make the person who is dying feel better or try to treat them but most of the time they just let nature take its course. Because of all the advances in medicine and development of life-sustaining technologies like mechanical ventilation, artificial nutrition and hydration, cardiopulmonary resuscitation, death is very different today than it was in the past as now it is possible to keep the human body functioning for some time even after recovery becomes impossible. This means that now death is not just a thing that happens, it has become a process which can be delayed or prolonged for some time.[3]

This change has led constitutional law to answer questions that previous generations of lawyers would not have considered. If medicine has the ability to keep someone alive for an indefinite period, must the State also act to perpetually preserve your biological existence? Conversely, if the Constitution guarantees you dignity and independence as an individual, does that right extend to those deeply personal choices that must be made as you approach the end of natural life? The answers to these questions are neither solely legal nor solely medical

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[3] TL Beauchamp and James F Childress, *Principles of Biomedical Ethics* (8th edn, Oxford University Press 2019) 157-162.

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in nature. Rather, they exist at the intersection of constitutional values, medical ethics and human experience.[4]

The Constitution of India, in Article 21, does not specifically state a 'right to die'.[5] The Constitution provides that a person's life and personal liberty may not be violated except after following due process. While the courts were originally interpreting this provision as a guarantee that judges would follow established procedures before depriving people of their lives and liberty, over time, the courts have interpreted the 'right to life' to be both a procedural right and a source of substantive rights. The Supreme Court has held on a number of occasions that the right to life means much more than mere animal existence.[6] An individual has the right not only to have a physical existence, but that the right also includes: the right to live with dignity; to have privacy; to have bodily integrity; and to have the ability to make decisions about one's own life, that is, the way in which someone will be able to live.[7]

The Constitution's discussion on Death and Dignity has evolved gradually with time. In *P. Rathinam v Union of India*, the Supreme Court held that the right to life could include a concurrent right not to live[8] although this ruling was subsequently overturned by a Constitution Bench in *Gian Kaur v State of Punjab,* which rejected the existence of a general right to die under Article 21 according to the Constitution of India.[9] Nevertheless, the Supreme Court held that it was possible for the right to life to include the right to a dignified natural death, particularly in cases where a terminally ill individual was dying naturally and was being allowed to die with dignity instead of being deprived of life.[10] What was thought at the time to be a cautious statement became the basis of Indian end-of-life jurisprudence.

The next milestone event took place after more than ten years, in the case of *Aruna Ramachandra Shanbaug v Union of India*. The Supreme Court, in this case, was faced with the tragic circumstance of a woman who had been in a continuous vegetative state for several decades. The court recognised passive euthanasia but under strict judicial supervision.[11] The

[4] Ronald Dworkin, *Life's Dominion: An Argument About Abortion, Euthanasia, and Individual Freedom* (Alfred A Knopf 1993) 179-217.
[5] Constitution of India 1950, art 21.
[6] *Francis Coralie Mullin v Administrator, Union Territory of Delhi* (1981) 1 SCC 608.
[7] *Justice KS Puttaswamy (Retd) v Union of India* (2017) 10 SCC 1.
[8] *P Rathinam v Union of India* (1994) 3 SCC 394.
[9] *Gian Kaur v State of Punjab* (1996) 2 SCC 648.
[10] ibid.
[11] *Aruna Ramachandra Shanbaug v Union of India* (2011) 4 SCC 454.

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case dealt largely with whether to withdraw life-sustaining treatment, but it also evidenced an emerging awareness by the Supreme Court that the constitutionally protected right of dignity cannot be separated from the experience of a person who is suffering for long periods of time and is irreversibly unable to communicate.

This evolution of constitutional principles reached its most important stage when the Supreme Court in *Common Cause v Union of India* held that the right to life under Article 21 of the Indian Constitution includes a qualified right to die with dignity.[12] The Supreme Court confirmed that advance directives regarding end-of-life treatment choices are valid and that individual autonomy does not lose its constitutional protection merely because an individual is in the last stages of life. Justice D.Y. Chandrachud, in his separate opinion, stated that the idea of dignified death is part of the constitutional commitment to autonomy, self-determination of every individual and the inherent worth of every individual. Instead of treating life and death as different constitutional categories, this case recognised that dignity accompanies individuals throughout the continuum of human existence.[13]

More recently, the decision of the Supreme Court in the matter concerning *Harish Ranav Union of India*[14]has demonstrated that the constitutional principles articulated in *Common Cause* are no longer confined to abstract judicial discourse. The Court's willingness to permit the withdrawal of life support in appropriate circumstances reflects an important shift from constitutional recognition towards practical implementation.[15] Yet this constitutional evolution reveals another equally significant story: the slow and often incomplete movement from the recognition of dignified death as a constitutional value to its meaningful implementation within everyday medical practice.

The progressive acknowledgement of the right to die with dignity has given rise to many legal and institutional mechanisms through which individuals may exercise their autonomy near the end of their lives. Competent people may use living wills or advance directives to state how they would like to be medically treated in the future if they were unable to communicate these choices to someone else. Passive euthanasia allows for the withholding and withdrawal of life-sustaining measures under strict regulations. In addition to these developments, Do-Not-Resuscitate (DNR) orders are another important but relatively

[12]*Common Cause (A Registered Society) v Union of India* (2018) 5 SCC 1.
[13]Common Cause (A Registered Society) v Union of India (2018) 5 SCC 1, paras 664–671 (per Chandrachud J).
[14]*Harish Rana v Union of India* [2026] INSC 222.
[15]Ibid.

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neglected way to make end-of-life choices. DNR orders do not intend to result in a person's death, in contrast to active euthanasia. Nor do they necessarily involve the withdrawal of ongoing treatment. They simply reflect a decision that cardiopulmonary resuscitation should not be attempted where such intervention would merely prolong the process of dying without offering any realistic prospect of recovery.[16]

Considerable scholarly attention has been focused on obtaining judicial recognition for the constitutional right to die with dignity; however, there has been little emphasis on how to actually implement this constitutional promise through routine medical practice. While passive euthanasia and advance directives may be referenced in discussions about arrangements for the end of life, they do not address the practical impact of Do-Not-Resuscitate (DNR) orders as an immediate mechanism to exercise one's autonomy at the end of life. In fact, DNR orders are generally the most commonly used practical clinical mechanisms through which individuals can exercise end-of-life autonomy.[17] Their importance extends beyond patient choice alone. Clear and legally recognised DNR protocols may also reduce uncertainty for physicians, minimise the risk of unnecessary or non-beneficial interventions, and alleviate the emotional and legal burden that often accompanies end-of-life decision-making.[18]

This article argues that the journey from *Gian Kaur* to *Common Cause* and, more recently, to the implementation witnessed in the Harish Rana decision reflects a remarkable constitutional evolution. However, the constitutional promise of dignity remains incomplete unless it is accompanied by coherent institutional mechanisms capable of protecting end-of-life autonomy in practice. By examining the constitutional development of the right to die with dignity alongside living wills, advance directives, passive euthanasia, and particularly Do-Not-Resuscitate orders, this article seeks to explore whether the Indian Constitution has truly begun to accompany individuals through the final and most personal decisions of human existence.

Research Methodology

[16] Indian Council of Medical Research, *Do Not Attempt Resuscitation (DNAR): Consensus Guidelines for Shared Decision-Making and Limiting Life-Sustaining Treatment* (2020).
[17] Ibid.
[18] Vidhi Centre for Legal Policy, 'ICMR Guidelines on Do Not Attempt Resuscitation: Move the Needle on End-of-Life Care' (2020).

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This Article takes an analytical and doctrinal approach to examining end-of-life decision-making. The sources of primary information for this research are: constitutional provisions, judicial decisions, statutes and professional medical guidelines on end-of-life care. Secondary sources such as academic literature, books, policy reports and comparative jurisprudence have also been used to support this Article. The Article also adopts a limited comparative perspective by drawing insights from international developments concerning end-of-life decision-making for the purpose of better understanding the evolving constitutional position in India.

II. THE MEANING OF DIGNITY AND END-OF-LIFE AUTONOMY

The concept that every person has an inherent value is much older than modern legal systems.[19] Long before laws or treaties started referring to dignity, philosophers had argued that a person's value should not come from their contribution to society, but simply from being a person. This view supports many of the ideas that are found in modern discussions about rights, equality and individual freedom.

Immanuel Kant, a German Philosopher, gave an important theory of human dignity. According to which, each and every person should be treated with respect as if they are an end in themselves and not just a means to an end. He thought that people should not be used merely as an instrument for the benefit of others or to make the State or society better. Every person possesses an inherent value that is not dependent upon age, health, productivity or social utility.[20] This take on dignity has been a significant influence in modern democratic governments because it acknowledges that the value of a person cannot be derived from external factors only.

While the concept of dignity is not simply the preservation of an individual's physical existence, modern constitutional jurisprudence is increasingly tying dignity to individuals' rights to choose the course of their lives.[21] Ronald Dworkin advanced this notion regarding euthanasia and end-of-life care, when he insisted that respecting human dignity requires us to respect each individual's ability to make highly personal choices about their lives.[22] As such,

[19] Jeremy Waldron, *Dignity, Rank and Rights* (Oxford University Press 2012) 13–20.
[20] Immanuel Kant, *Groundwork of the Metaphysics of Morals* (Mary Gregor and Jens Timmermann tr, rev edn, Cambridge University Press 2012) 42-43.
[21] Aharon Barak, Human Dignity: The Constitutional Value and the Constitutional Right (Cambridge University Press 2015) 105–118.
[22] Ronald Dworkin, *Life's Dominion: An Argument About Abortion, Euthanasia, and Individual Freedom* (Vintage Books 1994) 213–217.

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choices about one's body, about how one wants to be treated medically and how one would like their life to end, are not simply their personal preferences, but expressions of their autonomy and self-determination that should be legally recognised and protected.[23]

Over time, these philosophical ideas started to be included in constitutional law across various jurisdictions,[24] and the idea of dignity began to be understood as a constitutional principle, rather than only as an abstract moral value, that provides a way for individuals to protect their freedom from unwarranted State interference.[25] The recognition that every person has an inherent worth created the expectation that individuals should also have an appropriate level of control over any decisions concerning their own lives.

Similarly, Indian constitutional jurisprudence reflects an evolution. Although the Constitution does not specifically mention dignity under Article 21, but through judicial interpretation, the right to life has been transformed into a guarantee of more than just physical survival. Through many judicial decisions, the Supreme Court repeatedly identifies that the concept of life under Article 21 must be interpreted as a life lived with dignity.[26] The Supreme Court has also held that the Constitution does not simply protect biological existence, rather, the purpose for which the Constitution exists is to protect the conditions that help to give meaning to a person's life.[27]

The acknowledgment of dignity as a core value in the Constitution brings up an interesting point. If individual dignity ensures the right to make decisions on one's own while alive, then as soon as death is imminent, would that same dignity still protect the individual's right to make a choice? Today's medical technology allows for the biological continuation of an individual's life even when there are no longer any prospects for recovery. Thus, questions relating to refusal of treatment, removal of life-support systems, advance directives and do-not-resuscitate (DNR) seem to be as much a question of autonomy as they also are a question of medicine.

[23]Ronald Dworkin, *Life's Dominion: An Argument About Abortion, Euthanasia, and Individual Freedom* (Vintage Books 1994) 213–217; *Common Cause (A Registered Society) v Union of India* (2018) 5 SCC 1, paras 664–671 (per Chandrachud J).
[24] Neomi Rao, 'Three Concepts of Dignity in Constitutional Law' (2011) 86 *Notre Dame Law Review* 183, 185–90.
[25]*Justice KS Puttaswamy (Retd) v Union of India* (2017) 10 SCC 1.
[26]*Francis Coralie Mullin v Administrator, Union Territory of Delhi* (1981) 1 SCC 608.
[27]*Maneka Gandhi v Union of India* (1978) 1 SCC 248.

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End-of-life autonomy emerges out of the understanding of dignity. Autonomy at the end of life means that an individual can make decisions relating to medical treatment during the final stages of their life. Any competent individual should generally have the ability to choose if they will have treatment or not, especially when that treatment has little chance of providing them with any benefit and only prolongs their suffering. This does not necessarily imply a general right to die.[28] Rather, it reflects the belief that the constitutional protection of dignity should accompany an individual throughout the natural course of life, including the process of dying.

This understanding forms the foundation upon which the Indian Supreme Court gradually developed its jurisprudence on dignified death. The constitutional journey from *P. Rathinam* to *Common Cause* and the more recent developments concerning *Harish Rana* cannot be fully appreciated without recognising that the debate is not simply about death itself. At its heart, it concerns the extent to which the Constitution respects the inherent worth and personal autonomy of every individual, even in the final moments of human existence.[29]

III. THE CONSTITUTIONAL JOURNEY TOWARDS THE RIGHT TO DIE WITH DIGNITY

For a very long time, the belief in an individual's right to die has been thought to contradict the constitutional guarantee of the right to live. The role of law was to support life and prevent its unlawful deprivation. Because the Constitution supports both of these positions, there has historically been a disconnect between how the courts viewed the role of law and whether or not individual rights to die could be constitutionally protected. However, due to advances in modern medicine and the recognition of personal autonomy, courts have slowly begun to reconsider their previous views about death.[30]

The Supreme Court's *P. Rathinam* decision discussed the Indian Penal Code (IPC) Section 309,[31] an IPC section that criminalizes suicide attempts, and whether it had constitutional law validity.[32] The Supreme Court found that there is a Constitutional right to

[28] *Gian Kaur v State of Punjab* (1996) 2 SCC 648.
[29] *Common Cause (A Registered Society) v Union of India* (2018) 5 SCC 1.
[30] Law Commission of India, *Medical Treatment to Terminally Ill Patients (Protection of Patients and Medical Practitioners)* (196th Report, 2006) paras 2.1–2.15.
[31] Sec. 309 of the Indian Penal Code – 'Whoever attempts to commit suicide and does any act towards the commission of such offence, shall be punished with simple imprisonment for a term which may extend to one year or with fine, or with both.'
[32] *P Rathinam v Union of India* (1994) 3 SCC 394.

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live under Article 21 of the Constitution, as well as a right not to live. The Court concluded that just as freedom of speech includes freedom to remain silent, the right to live also includes freedom from the obligation to live. The Court connected the decision to end one's life with individual liberty and right to choose.[33]

While *P. Rathinam*'s judgment brought a new understanding of Article 21, it was also subject to critique. The notion that the right to life could also include a right to die raised significant constitutional and conceptual challenges. Since the purpose of the Constitution is to guarantee the protection of life, will it permit a right which will destroy that same life? Because of these uncertainties, the issue proceeded to the Constitution Bench of the Supreme Court.

In *Gian Kaur*, the Court reversed *P. Rathinam*'s decision and rejected the notion that Article 21 contains a general right to die.[34] In their judgment, the Court found that our Constitution expressly recognizes the natural right to life, and termination of life cannot be exercised as a constitutional right. The Supreme Court stated that Section 309 of the Indian Penal Code is constitutional, and found that although every individual has a right to life, that does not mean that one has an inherent right to end their life.[35]

At first glance, *Gian Kaur* appeared to close the constitutional debate. However, one of the most important aspects of the judgment lay in an observation that occupied only a small part of the decision which was the difference between the unnatural end to one's life and the natural process of dying.[36] The right to live free from indignity until one dies a natural death includes the right to die naturally, both when a person is terminally ill or in a persistent vegetative state. Although the Court did not provide guidance as to the legal ramifications of the preceding statement, the Court established an important constitutional foundation for future cases.[37]

Aruna Shanbaug marked yet another milestone as it involved extraordinary facts. Aruna Shanbaug had been in a permanent vegetative state for many years due to an act of violence against her and so a plea seeking withdrawal of life support was presented to the Supreme Court. For the first time in India, the Court had to address questions that Indian

[33] ibid.
[34] *Gian Kaur v State of Punjab* (1996) 2 SCC 648.
[35] ibid.
[36] ibid.
[37] ibid.

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judiciary had never faced before.[38] The Court ultimately gave recognition to passive euthanasia under strict judicial supervision and laid down detailed procedural safeguards for such decisions.[39]

The importance of *Aruna Shanbaug* lies not merely in its recognition of passive euthanasia, but in the manner in which it shifted the constitutional conversation. The focus gradually moved away from whether life should be preserved at all costs and towards whether the law should compel an individual to undergo medical intervention when recovery had become impossible. In many ways, the judgment reflected a growing judicial awareness that preserving biological existence is not always identical to preserving human dignity.[40]

The constitutional journey reached its most significant stage in *Common Cause* which was decided by a Constitution Bench. The judgment finally recognised that the right to life under Article 21 includes the right to die with dignity.[41] Unlike the earlier cases, the Court was no longer concerned solely with the validity of criminal provisions or with a single request for withdrawal of treatment. Instead, it considered whether an individual should have the authority to make decisions concerning medical treatment during the final stages of life.[42]

The Court concluded that advance medical directives and living wills were not unconstitutional.[43] A competent and adequately capable person can decide in advance whether or not they wish to be provided extraordinary or life sustaining medical treatment when they have reached a point where there is no reasonable chance of recovery. The ruling recognised that the concept of autonomy does not lose its constitutional status just because a person is in the last stages of their life.[44] In addition, the right to make personal decisions about one's own body and choices regarding medical treatment was central to living with dignity.

Justice D.Y. Chandrachud, in his separate opinion, expanded upon the notion that a dignified death is fundamentally constitutional. He stated that the Constitution affords each person the freedom to determine how they will lead their lives based on individual values and

[38] *Aruna Ramachandra Shanbaug v Union of India* (2011) 4 SCC 454.
[39] Law Commission of India, *Passive Euthanasia: A Relook* (241st Report, 2012) paras 1.10–1.25.
[40] *Aruna Ramachandra Shanbaug v Union of India* (2011) 4 SCC 454.
[41] Common Cause (A Registered Society) v Union of India (2018) 5 SCC 1; Law Commission of India, *Passive Euthanasia: A Relook* (241st Report, 2012).
[42] *Common Cause (A Registered Society) v Union of India* (2018) 5 SCC 1.
[43] ibid.
[44] Law Commission of India, Passive Euthanasia: A Relook (241st Report, 2012) paras 5.1–5.12.

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beliefs. He concluded that personal autonomy, bodily integrity and dignity should not be seen as mutually exclusive, but rather as principles that remain with an individual throughout all of human existence. The judgment recognised that life and death cannot always be viewed as completely separate constitutional categories because the process of dying is itself a part of life.[45]

While *Common Cause* established the constitutional foundation of dignified death, practical difficulties soon became apparent. The elaborate procedural safeguards surrounding advance directives and withdrawal of treatment made implementation extremely difficult in ordinary medical settings. There have often been inconsistencies regarding what medical facilities, physicians and families must accomplish legally before any decisions are made to either discontinue or withdraw life-sustaining measures. The Supreme Court addressed those issues by changing many of the procedural requirements in 2023 that affect how advance directives will operate in real life and making those processes much easier.[46]

The recent *Harish Rana* decision reflects a continuing constitutional evolution of end-of-life rights. If *Gian Kaur* introduced the possibility that dignity could accompany the process of natural death, and *Common Cause* transformed that possibility into a constitutional guarantee, *Harish Rana* demonstrates the judiciary's growing willingness to translate those principles into practical reality. The decision reflects an important movement from constitutional recognition towards constitutional implementation.[47]

However, this process of realising end-of-life autonomy still has a long way to go. Judicial recognition alone of the Constitution's promise of dignity does not mean that it will become part of everyday medical practice. The establishment of institutional mechanisms through which patients, families and health care providers have the opportunity to make informed and effective decisions about end-of-life care is a prerequisite for the effective exercise of end-of-life autonomy. In this broader constitutional context, advance directives, living wills and Do Not Resuscitate orders take on unique significance.[48]

[45] *Common Cause (A Registered Society) v Union of India* (2018) 5 SCC 1 (Chandrachud J).
[46] *Common Cause v Union of India* (2023) 11 SCC 265.
[47] *Harish Rana v Union of India* [2026] INSC 222.
[48] Indian Council of Medical Research, *Do Not Attempt Resuscitation (DNAR): Consensus Guidelines for Shared Decision-Making and Limiting Life-Sustaining Treatment* (2020).

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IV. FROM CONSTITUTIONAL RECOGNITION TO MEDICAL PRACTICE: LIVING WILLS, ADVANCE DIRECTIVES AND DO-NOT-RESUSCITATE ORDERS

The Supreme Court's interpretation of dignified death as a constitutional right was a landmark moment in our development as a society. However, constitutional recognition alone does not automatically enable individuals to exercise that right in practice. End-of-life decisions are rarely made inside courtrooms. In most cases, such decisions are often made in hospitals and require the collaboration of family members, physicians, and patients and are often made under emotional duress. Therefore, the degree to which the constitutional right to die with dignity can be enforced depends heavily upon whether there are established methods for making end-of-life medical decisions that have legal standing.[49]

Living wills are one of those methods. A living will is a legally valid document created in writing that expresses how an individual wishes to be treated medically in case they become unable to communicate these wishes in the future, due to an illness, being unconscious, or having lost their cognition. A living will provides for someone else's wishes when they are no longer capable of expressing those wishes.[50]

Advance directives are often thought to be synonymous with living wills, though generally speaking, advance directives are a more comprehensive term and encompass directions regarding all forms of medical treatment, including life-sustaining treatments, the use of artificial ventilation, CPR, or any other form of medical intervention. The recognition of advance directives in *Common Cause*[51] represented an important acknowledgement that personal autonomy does not disappear when an individual becomes incapable of expressing consent.[52]

The importance of advance directives and living wills is that they allow for the continuation of an individual's right to choose in situations where the individual can no longer communicate their will directly. In the absence of advance directives or living wills, those decisions are left to family members and/or healthcare professionals, both of whom have the best intentions in making medical decisions but who may have a significantly

[49] *Common Cause (A Registered Society) v Union of India* (2018) 5 SCC 1.
[50] ibid.
[51] ibid.
[52] Thaddeus Mason Pope, 'Legal Fundamentals of Surrogate Decision Making' (2012) 27 *New York State Bar Association Health Law Journal* 29.

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different interpretation of what the patient would want. Thus, advance directives provide a means of preserving the patient's voice after they are physically incapable of voicing a desire for medical treatment.[53]

The Supreme Court's acceptance of passive euthanasia should be understood in relation to end-of-life autonomy. Passive euthanasia is the withholding or discontinuance of medical treatment that provides artificial support for life where there is no reasonable chance of recovering from the condition. Whereas, active euthanasia is defined as a positive act done by someone that is intended to cause a person's death. Indian laws prohibit active euthanasia, however, courts have gradually recognised the legality of passive euthanasia because it generally enables an individual to die naturally without employing extraneous medical intervention.[54]

Recently, issues of living wills, advance directives, and passive euthanasia have received significant attention in legal discussions, but there has been comparatively less exploration of DNR orders (Do Not Resuscitate orders). A DNR order performs as a directive to medical caregivers notifying them that should the patient's heart or breathing cease, cardiopulmonary resuscitation (CPR) should not be attempted. In comparison to active euthanasia, a DNR order does not seek to cause the patient's death. DNR orders usually come into play when a person dies, or their heart has stopped, and while CPR or other medical measures like shock treatments may be able to prolong that person's life, DNR orders act against such acts of saving life, and they represent the patient's own will.[55]

Resuscitation is often considered a life-saving intervention, however, its effectiveness depends majorly upon the medical condition of the patient. Patients with a terminal illness, advanced organ failure or irreversible medical deterioration will have a lesser chance for recovery if resuscitated and instead, it might only prolong the patient's suffering or extend the dying process without improving the quality of their life.[56] Thus, if the primary concern of a

[53] *Common Cause (A Registered Society) v Union of India* (2018) 5 SCC 1; Ronald Dworkin, Life's Dominion: An Argument About Abortion, Euthanasia, and Individual Freedom (Vintage Books 1994) 198–205.
[54] *Aruna Ramachandra Shanbaug v Union of India* (2011) 4 SCC 454; *Common Cause (A Registered Society) v Union of India* (2018) 5 SCC 1.
[55] Indian Council of Medical Research, *Do Not Attempt Resuscitation (DNAR): Consensus Guidelines for Shared Decision-Making and Limiting Life-Sustaining Treatment* (2020).
[56] Lalit Kumar and others, 'End-of-Life Care and Resuscitation Decisions in India' (2020) 24 *Indian Journal of Critical Care Medicine* 1.

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patient is dignity and autonomy, the decision not to attempt resuscitation may be consistent with these values.[57]

DNR orders also possess an important practical advantage. Unlike living wills, which may be executed years before they are needed, or court-directed procedures involving withdrawal of treatment, DNR decisions frequently arise within the ordinary course of medical care. They therefore occupy a unique position at the intersection of constitutional values and everyday clinical practice.[58] For many patients, a DNR order may become the most immediate and realistic mechanism through which end-of-life autonomy is exercised.[59]

The importance of DNR orders extends beyond patient choice alone. Doctors often face ethical and legal uncertainty when making decisions relating to end-of-life care. Without adequate clarity and guidance, defensive practices will likely take place in the field of medicine where treatments are provided mostly due to fear of ramifications involved with any potential malpractice suits as opposed to providing medical care with any value. An appropriately regulated DNR protocol will create a clear and truthful way to make these types of decisions with consistency and transparency, thus alleviating this uncertainty.[60]

Recognizing this uncertainty, and to clarify this process, the Indian Council of Medical Research (ICMR) developed guidelines regarding the Do-Not-Attempt-Resuscitation (DNAR) decision-making process that emphasise the collaboration of healthcare providers and their clear communication with both patients and their families, as well as respecting patients' autonomy.[61] The guidelines were also set up to protect the healthcare provider's professional medical judgment. Although they are not legally enforceable like a law or statute, the guidelines are a significant effort to assist in bridging the gap between constitutional principles and practices in medicine.[62]

[57]Indian Council of Medical Research, *Do Not Attempt Resuscitation (DNAR): Consensus Guidelines for Shared Decision-Making and Limiting Life-Sustaining Treatment* (2020).
[58]World Medical Association, *Declaration on End-of-Life Medical Care* (2022).
[59]Indian Society of Critical Care Medicine and Indian Association of Palliative Care, 'End-of-Life Care Policy: An Integrated Care Plan for the Dying' (2014) 18 *Indian Journal of Critical Care Medicine* 615.
[60] Atul Gawande, *Being Mortal: Medicine and What Matters in the End* (Metropolitan Books 2014) 145–178; Vidhi Centre for Legal Policy, 'ICMR Guidelines on Do Not Attempt Resuscitation: Move the Needle on End-of-Life Care' (2020).
[61] Indian Council of Medical Research, *Do Not Attempt Resuscitation (DNAR): Consensus Guidelines for Shared Decision-Making and Limiting Life-Sustaining Treatment* (2020).
[62] Indian Council of Medical Research, Expert Consensus Based Consensus Guidelines on End-of-Life Care for the Dying (2018).

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While ICMR's guidelines are very beneficial, challenges still exist in this type of decision making. The lack of public awareness regarding living wills, advance directives, and DNR orders limits individuals' ability to pursue these options. Many people do not even know that such mechanisms exist until they are faced with a medical crisis. Different hospitals also have their own end-of-life decision-making practices, which are not standardised for all hospitals. Thus, the actual ability of individuals to make informed decisions regarding their autonomy does not usually correlate to constitutional principles, but rather relates to institutional practices.[63]

The disparity between constitutional recognition and actual application of rights in the context of death represents one of the greater impediments to developing a viable end-of-life framework in India. While dignity and autonomy at the end of life have been recognised more and more by the Constitution, how well those values are enacted and applied relies upon the institutions administering those values. As such, there exists both an opportunity and a need to conduct a deeper analysis of the gap between constitutional promise and the actual practice.[64]

V. PROMISE AND PRACTICE: THE UNFINISHED CONSTITUTIONAL JOURNEY

The constitutional recognition of the right to die with dignity is among the most important developments in interpreting Article 21. There has been a significant change in how the Indian judiciary has interpreted and applied this autonomy at the end stage of life, as seen through the journey from the apprehensive observations in *Gian Kaur*, to the advancements related to advance directives established in *Common Cause*, and finally, to practical implementation seen through *Harish Rana*. The gradual progression of the Indian judiciary has transitioned to a more autonomy-based perspective regarding end-of-life decision-making. However, this evolution still highlights that the journey to obtaining constitutional recognition to practical implementation has yet to be fulfilled.[65]

Constitutional rights mean nothing unless individuals are able to exercise and realize their rights through practical implementation. While dignity and autonomy have been continually recognized by the Supreme Court as essential elements of constitutional rights,

[63]Vidhi Centre for Legal Policy, 'ICMR Guidelines on Do Not Attempt Resuscitation: Move the Needle on End-of-Life Care' (2020).
[64]Vidhi Centre for Legal Policy, 'ICMR Guidelines on Do Not Attempt Resuscitation: Move the Needle on End-of-Life Care' (2020).
[65]*Gian Kaur v State of Punjab* (1996) 2 SCC 648; *Common Cause (A Registered Society) v Union of India* (2018) 5 SCC 1; *Harish Rana v Union of India* [2026] INSC 222.

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the actual realization of dignity and autonomy primarily depends upon institutions that operate outside the courtroom. Most end-of-life decisions occur in hospitals, intensive care units, and emergency rooms and not in constitutional courts. The efficacy of the right to die with dignity, therefore, is predicated on both the judges' recognition of such rights and the ability of the medical institutions to implement those rights in a consistent manner.

A major hurdle in this area is a general lack of public awareness regarding the process of making end-of-life decisions. Even though the Supreme Court has endorsed living wills and advance directives, many people remain unaware of the existence of such mechanisms.[66] Most discussions about end-of-life care decisions occur only after a serious medical issue has developed. After the point where the patient is unable to communicate their desires, the families of the patient and the medical professionals must make difficult end-of-life decisions without any input from the person whose life will ultimately be affected by those decisions.[67]

Difficulties with making end-of-life decisions exist at the hospital level as well. While several procedural requirements have been simplified by the Supreme Court in 2023, the procedures used to implement advance directives and withdraw treatment are still quite complex.[68] Each hospital has its own procedures and internal requirements and/or is associated with different philosophies about what to do at the end of life. Therefore, the extent to which an individual can exercise end-of-life autonomy may depend upon the institution in which they receive treatment rather than upon a uniform constitutional framework.

The position of medical professionals presents another important concern. Physicians are frequently required to make difficult decisions involving competing ethical obligations. On one hand, they have a professional duty to preserve life wherever possible. On the other hand, they must also respect patient autonomy and avoid treatment that serves little medical purpose while prolonging suffering. In the absence of clear legal protection, doctors may continue treatment primarily out of concern regarding future legal liability. This fear can

[66]Vidhi Centre for Legal Policy, 'ICMR Guidelines on Do Not Attempt Resuscitation: Move the Needle on End-of-Life Care' (2020); Vidhi Centre for Legal Policy, *End-of-Life Decision-Making in India: The Way Forward* (2021) 24–31.
[67]See also *R (Tracey) v Cambridge University Hospitals NHS Foundation Trust* [2014] EWCA Civ 822 (United Kingdom), recognising the importance of patient involvement in Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions.
[68] Common Cause v Union of India (2023) 11 SCC 265.

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discourage meaningful conversations concerning withdrawal of treatment, advance directives and DNR decisions even where such discussions may be medically appropriate.[69]

The challenges become even more apparent in the context of DNR orders. Unlike constitutional litigation, DNR decisions arise in real time and often require immediate action.[70] The effectiveness of such decisions depends upon communication between patients, families and healthcare providers, as well as confidence that the decision will be respected within the legal framework. When physicians cannot be certain that DNR directions reflect a patient's preference, they may hesitate to act on them. As a result, the constitutional promise of autonomy may fail to translate into practical decision-making at the very moment when it is most needed.

The existing gap between what is written in the Constitution and how those things are put into practice demonstrates that there are challenges inherent in India's entire constitutional framework. Simply declaring a right in court is only the beginning of a more extensive and lengthy process, the true value of a right is only found when the right can be exercised consistently throughout the course of everyday life.[71] The evolution of the right to die with dignity highlights this distinction. Although courts have created a legal framework for ensuring that individuals have the right to die with dignity, many other factors limit this opportunity. One of these factors is how well courts understand legal concepts related to the provision of dignity at death. Other factors include whether or not other members of the healthcare system understand what it means to provide dignity at death and if the healthcare system provides resources necessary for a person experiencing the end-of-life event to have the ability to die with dignity.

Thus, the development of end-of-life law in India is better considered as an ongoing project under construction as opposed to being established law. Significant progress has been made from the decisions rendered in *Gian Kaur* through *Common Cause* and *Harish Rana*; however, there are still numerous barriers that exist in the way of dying patients and their care providers in order to obtain dignity at death. While the constitutional guarantee of dignity continues to expand, the achievement of the complete implementation of the

[69]Indian Council of Medical Research, *Do Not Attempt Resuscitation (DNAR): Consensus Guidelines for Shared Decision-Making and Limiting Life-Sustaining Treatment* (2020); Vidhi Centre for Legal Policy, 'ICMR Guidelines on Do Not Attempt Resuscitation: Move the Needle on End-of-Life Care' (2020).
[70] World Medical Association, Declaration on End-of-Life Medical Care (2019).
[71] The Lancet Commission, 'The Value of Death: Bringing Death Back into Life' (2022) 399 *The Lancet* 837.

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constitutional guarantee of dignity will require additional support systems for individuals to exercise their autonomy with respect to their end-of-life care.

VI. REIMAGINING THE CONSTITUTIONAL PROMISE OF DIGNITY

By recognising the right to die with dignity as part of constitutional law, the Supreme Court took a giant step toward advancing those values as legal concepts and protecting them under Indian law. Through the *Common Cause* and *Harish Rana* cases, there is an evident trend of Indian constitutional law recognising and protecting the autonomy, dignity and self-determination of an individual until the end of that person's life. However, just because some of these values are now recognised in the Constitution does not mean that people will experience them as meaningful. The main challenge presented in the creation of a system that provides people with the ability to exercise their autonomy, dignity and self-determination is the translation of constitutional principles into workable and effective systems that function outside the courtroom.[72]

Public education is another area that deserves greater attention. Living wills, advance directives and DNR orders can only be effective when individuals know about them;[73] therefore, the more we are able to encourage individuals to take part in discussions relating to their wishes for end-of-life care, the better they will be able to think through their options. Currently, discussions regarding an individual's end-of-life care preferences usually take place only after an individual is already facing a serious medical emergency. By facilitating earlier discussions of an individual's medical preferences with family members and physicians, individuals can play a much more meaningful role in their end-of-life care decisions that will ultimately shape how they experience the final stage of life.[74]

There is also a need for more uniformity between medical institutions. A patient's ability to exercise end-of-life autonomy should not depend on the type of facility where they receive care or on the familiarity level of hospital staff with the currently available protocols. More uniformity in hospital policies, documentation requirements and action implementation

[72] *Common Cause (A Registered Society) v Union of India* (2018) 5 SCC 1; *Harish Rana v Union of India* [2026] INSC 222.
[73] Vidhi Centre for Legal Policy, End-of-Life Decision-Making in India: The Way Forward (2021).
[74] Vidhi Centre for Legal Policy, 'ICMR Guidelines on Do Not Attempt Resuscitation: Move the Needle on End-of-Life Care' (2020).

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will allow for more consistent application of constitutional protections among the various healthcare settings.[75]

The ethical and legal perspectives of healthcare workers must also be taken into account equally with those of patients. Healthcare providers face ethical issues (e.g., prior to making decisions about whether to allow patients to have autonomy) as well as complex legal issues related to the care of critically ill patients simultaneously. Even though there have been important judicial rulings and healthcare provider guidelines, uncertainty persists at present regarding what those standards are.[76] A clearer legal framework governing advance directives, withdrawal of treatment and DNR decisions will enhance patient autonomy, as well as provide healthcare providers with increased confidence that they are complying with both applicable law and the patient's wishes.

The future development of end-of-life law in India must therefore move beyond the question of whether dignity exists as a constitutional value. That question has largely been answered by the courts. The more pressing question is how dignity can be protected consistently in everyday medical practice. The constitutional promise of dignity cannot be realised merely through judicial recognition, but it will also take legal, medical and institutional infrastructures to support an individual's choice at the end of life.[77]

Ultimately, the significance of dignity lies in its ability to accompany an individual through every stage of human existence. If dignity informs the manner in which people live, it must also inform the manner in which they approach death.[78] The constitutional journey from *Gian Kaur* to *Common Cause* and *Harish Rana* reflects remarkable progress;however, themain obstacle that remainsis to ensure that the values recognised in constitutional doctrine are capable of being experienced by individuals when they need them most.[79]

VII. CONCLUSION

The constitutional conversation surrounding death has never truly been about death alone. At its core, it is about whether the Constitution recognises an individual as a person

[75] Indian Society of Critical Care Medicine and Indian Association of Palliative Care, 'End-of-Life Care Policy: An Integrated Care Plan for the Dying' (2014) 18 *Indian Journal of Critical Care Medicine* 615.
[76]Indian Council of Medical Research, *Do Not Attempt Resuscitation (DNAR): Consensus Guidelines for Shared Decision-Making and Limiting Life-Sustaining Treatment* (2020).
[77]World Medical Association, *Declaration on End-of-Life Medical Care* (2022).
[78] Ronald Dworkin, *Life's Dominion* (Vintage Books 1994) 213–217; Aharon Barak, *Human Dignity: The Constitutional Value and the Constitutional Right* (Cambridge University Press 2015) 359–366.
[79]*Gian Kaur v State of Punjab* (1996) 2 SCC 648; *Common Cause (A Registered Society) v Union of India* (2018) 5 SCC 1; *Harish Rana v Union of India* [2026] INSC 222.

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having legal standing, that is, the freedom of an individual to make deeply personal choices regarding their life and how they want to live it. The development of the right to die with dignity in India from *P. Rathinam* to*Gian Kaur*, *Aruna Shanbaug*, *Common Cause* and *Harish Rana* marks an important progression of Indian constitutional law and its approach to issues regarding death.[80] Initially, there was a judicial reluctance to answer questions relating to death, which has gradually evolved into a recognition that dignity, autonomy and self-determination do not lose their constitutional significance simply because an individual approaches the end of life.[81]

However, whilst legal recognition of these principles represents progress, they alone cannot guarantee the meaningful exercise of these values. And like this Article has argued, living wills, advance directives, passive euthanasia and Do-Not-Resuscitate orders are not merely medical mechanisms; they are the practical means through which constitutional dignity is realised. Their effectiveness ultimately depends upon public awareness, institutional preparedness and the confidence of medical professionals responsible for implementing them.

The Constitution was never intended merely to preserve biological existence. Its deeper purpose is the protection of dignity that confers meaning to existence itself.[82] The story of end-of-life autonomy in India therefore remains unfinished. The law has begun to acknowledge the existence of a constitutional space between the preservation of life at all costs and the premature cessation of life, and that space is occupied by dignity. The future of Indian end-of-life jurisprudence will depend not only upon further judicial recognition, but upon the ability of legal and medical institutions to translate constitutional values into lived realities. Only then can the promise of dignity accompany individuals through the final and most personal decisions of human existence.

[80] *P. Rathinam v Union of India* (1994) 3 SCC 394; *Gian Kaur v State of Punjab* (1996) 2 SCC 648; *Aruna Ramachandra Shanbaug v Union of India* (2011) 4 SCC 454; *Common Cause (A Regd Society) v Union of India* (2018) 5 SCC 1; *Harish Rana v Union of India* [2026] INSC 222.

[81] *Common Cause (A Regd Society) v Union of India* (2018) 5 SCC 1, per Chandrachud J.

[82] *Francis Coralie Mullin v Administrator, Union Territory of Delhi* (1981) 1 SCC 608; *Common Cause (A Regd Society) v Union of India* (2018) 5 SCC 1.

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