

Common Cause (A Regd. Society) v. Union of India [2018] INSC 223: End-of-life care in India

Medical Law International
2025, Vol. 25(2) 136–146

© The Author(s) 2025



Article reuse guidelines:
sagepub.com/journals-permissions
DOI: 10.1177/09685332251315929
journals.sagepub.com/home/ml



Ranjit I. James 
Christian Medical College Vellore, India

Senthil Kumaran
Gerard P. Devnath
All India Institute of Medical Sciences, Madurai, India

Raj K. Mani 
Yashoda Super Speciality Hospital, India

Abstract

The discourse on the right to die and end-of-life care autonomy, advocating for a dignified and humane end, has gained significant traction globally, including in India. Emphasizing individual choice and autonomy, this debate spans various health spectrums as individuals seek control over their deaths to avoid unnecessary suffering and alleviate family burdens, particularly in intensive care unit settings. However, concerns about potential abuse and the need for stringent safeguards if passive euthanasia, that is withdrawal and withholding of life support, were legalized have emerged, especially regarding the medical profession's role and individual vulnerability. In India, where end-of-life legal frameworks are evolving, the Supreme Court recognized the right to die with dignity as a fundamental right (it only includes the right to refuse treatment) under Article 21 of the Constitution. This commentary will critically examine the landmark judgement in line with end-of-life care in India to argue that while the judgement is progressive in principle, it does not go far enough in procedural simplification.

Keywords

Advance directive, euthanasia, living will, right to die, Supreme Court of India

Received 23 October 2024; Revised 01 December 2024; Accepted 12 January 2025

Corresponding author:

Raj K. Mani, Department of Critical Care, Yashoda Super Speciality Hospital, Near Metro Station, Kaushambi, Ghaziabad 201012, Uttar Pradesh, India.
Email: raj.rkmjs@gmail.com

Background

The discourse surrounding the right to die and end-of-life care autonomy, rooted in the desire for a dignified and humane end to life, has gained significant traction worldwide, including in India. Fundamental principles of choice and autonomy resonate strongly, transcending various health spectrums, as individuals seek control over their deaths to avoid unnecessary suffering and mitigate burdens on their families, especially in the intensive care unit (ICU). However, concerns about potential abuse and the need for stringent safeguards if considered treatment limitations were to be legalized have emerged, particularly regarding the role of the medical profession and the vulnerability of individuals. In 2015, India ranked 67th out of 80 countries in the ‘Quality of Death Index’, published by the Lien Foundation in collaboration with the Economist Intelligence Unit.¹ Recently, Finkelstein and colleagues conducted a cross-country comparison of expert assessments on the quality of death and dying, placing India at 59th among 81 countries studied.² Overall, the discourse of the assessment underscores the intricate interplay between individual autonomy, family involvement, and the prevention of potential abuse in end-of-life care decisions in India.³ This commentary focuses on the landmark verdict of the Hon’ble Supreme Court of India delivered in 2018, which deemed the ‘right to die with dignity’ a fundamental right and argues that while the judgement is progressive in principle, it does not go far enough in procedural simplification. In the first part, we will examine the judgement; the second part will focus on the modifications of the judgement by the apex court; the third part will have a critical analysis and the impact of this judgement.

The historical judgement

Facts of the case

Common Cause, the non-governmental organization, initiated the saga of the dignified death debate in 2002.⁴ At that time, the organization penned letters to the Ministries of Law & Justice, Health & Family Welfare, and various state governments, initiating a dialogue on the topic.⁵ This marked the initial step in sparking a conversation on death ethics in India. It highlighted the pressing need to address the distressing pain and challenges faced by the elderly, especially concerning serious illnesses requiring hospital treatment.⁶ Regrettably, no response was received to these communications from the concerned. Hence, through a Writ Petition in 2005, the petitioner urged the Hon’ble

1. ‘*Quality of Death Index*’, Pallium India, 29 January 2022, available at <https://palliumindia.org/2022/01/quality-of-death-index-2021> (accessed 8 July 2024).

2. Ibid.

3. *Aruna Ramachandra Shanbaug v. Union of India and Others* [2011] INSC 67, para 127.

4. Writ Petition (Civil) No. 215/2005 in the Supreme Court of India by Common Cause (A Regd. Society).

5. Ibid., para 12.

6. Ibid., para 1.

Supreme Court of India to recognize the ‘right to die with dignity’ (distinct from an absolute ‘right to die’) as a fundamental right under Article 21 of the Constitution for all citizens.⁷

In addition, the petitioner sought directives from this Hon’ble Court, compelling the respondents to establish appropriate procedures in consultation with State Governments if necessary. These procedures would facilitate individuals in deteriorating health or those terminally ill to draft a document titled ‘My Living Will & Attorney Authorisation’. This document should be presented at the time of hospitalization to be integrated into healthcare decision-making. Alternatively, the petitioner requested the issuance of suitable guidelines to ensure the protection of fundamental rights for such individuals and to secure their rights against infringements or violations of any kind.⁸

The judgement

In the context of India, where legal frameworks governing end-of-life decisions are still evolving, the trajectory recently culminated in a significant milestone. The Supreme Court of India’s landmark judgement in 2018 recognized the right to die with dignity as a fundamental right.⁹ This decision, a culmination of the evolving legal landscape, underscored the patient’s autonomy and privacy.^{10,11} While acknowledging the patient’s right to autonomy, the ruling unequivocally recognizes the right to refuse any treatment. It also recognizes the legal validity of living wills/advances directives (concerning treatment refusals/limitations), thus allowing for values and wishes of patients to be documented while they still retain capacity.¹² It also laid down procedures for those who do not have an advance directive.¹³ In addition, the judgement empowers a healthcare power of attorney to participate in end-of-life care decisions on behalf of the patient.¹⁴

The Hon’ble Court has analysed *Gian Kaur*¹⁵ and *Aruna Shanbaug* case¹⁶ in detail while adjudicating the said case. It clarified that in the *Gian Kaur*’s case, which dealt with the attempt to commit suicide,¹⁷ and the abetment to commit suicide,¹⁸ while the

7. Constitution of India, 1950. Article 21 guarantees the fundamental right to the Protection of life and personal liberty: No person shall be deprived of his life or personal liberty except according to procedure established by law.

8. Cf (n 4), para 4.

9. *Common Cause (A Regd. Society) v. Union of India & Another* [2018] INSC 223.

10. Cf (n 7).

11. *Justice K. S. Puttaswamy (Retd.) & Anr. v. Union of India & Ors.*, [2017] INSC 1235.

12. *Common Cause* (n 9), p. 170.

13. *Ibid.*, p. 182.

14. *Ibid.*, p. 172.

15. *Gian Kaur v. The State of Punjab* [1996] INSC 418.

16. *Aruna* (n 3).

17. 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.’

18. Sec. 306 of the Indian Penal Code – ‘If any person commits suicide, whoever abets the commission of such suicide, shall be punished with imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine.’

‘right to life’ did not encompass the ‘right to die’, the ‘right to die with dignity’ is inherent within the right to life. The Bench also said that the right to a natural death with dignity should not be conflated with the right to end one’s life unnaturally. The reliance on this interpretation has been thought to have been derived from *Bland*’s case,¹⁹ wherein it was about matters concerning the withdrawal and withholding of artificial measures that prolong life, stating

The desirability of bringing about a change was considered to be the function of the legislature by enacting a suitable law providing therein adequate safeguards to prevent any possible abuse.²⁰

However, the Hon’ble Court has neither approved the above ratio nor expressed an independent decision as interpreted in the *Bland* case, wherein it was clarified that it is an obiter. Surprisingly, the apex court in the *Aruna Shanbaug* case has interpreted the *Bland* position to mean that ‘passive euthanasia’ would eventually need a legislative process.²¹ On the other hand, the court expressed the view that the *Gian Kaur* verdict is not a binding legal precedent for the principle that passive euthanasia can be made lawful only through the enactment of legislation.²²

Furthermore, the Supreme Court compared the international positions with respect to passive euthanasia and observed the 241st Report of the Law Commission of India had underscored human rights perspectives and ethical rationale to be integrated into such complex matters.²³ This was discussed along with the notion of right to refuse treatment.²⁴

The next issue which the Supreme Court deliberated is evaluating passive euthanasia within the context of Article 21 of the Indian Constitution, which states, ‘No person shall be deprived of his life or personal liberty except according to procedure established by law’. It observed that ‘there is no doubt that no fundamental right is absolute, but any restraint imposed on liberty has to be reasonable’,²⁵ and concluded that ‘passive euthanasia comes within the sweep of Article 21 of the Constitution, we have no iota of doubt that this Court can lay down the guidelines’.²⁶ In addition, it inferred that individual dignity,²⁷ right of self-determination, and individual autonomy are encompassed within Article 21 of the Constitution.²⁸ Thus, the apex court has ruled that the ‘right to die with dignity’ is a fundamental right and provided legal validity to advance directives (AD)

19. *Airedale N.H.S. Trust v. Bland* [1993] 2 WLR 316.

20. Justice Jagdish Saran Verma *Gian* (n 15), para 41.

21. *Common Cause* (n 9), para 42.

22. *Ibid.*, para 43.

23. Law Commission of India, *Passive Euthanasia – A Relook* (Law Com Rep No 241, 2012).

24. *Common Cause* (n 9), p. 120.

25. *Ibid.*, para 138.

26. *Ibid.*, para 144.

27. *Ibid.*, para 160.

28. *Ibid.*, para 169.

and the power of healthcare attorney.²⁹ While it is a promising step, the Hon'ble Supreme Court has been concerned with the potential misuse of the provisions, thus laying down multilayered measures to safeguard the patients admitted to the hospital.³⁰

Is this enough?

It is to be noted that although the judgement aligns with the existing global practices and positions in principle for end-of-life care issues, which uphold the patient's personhood, it also encourages shared decision-making with treating physicians, thereby balancing patient autonomy with physician duties of care. This process allows for complete information to be shared with the patient/next of kin about the diagnosis of medical futility and the options for foregoing life-sustaining treatment. In addition, this aligns with the principles of medical ethics, which is not only about patient autonomy and physician duties to act in beneficence and non-maleficence but also about distributive justice in the interest of the larger good.

The law has evolved over time not to obstruct but to facilitate justice for the people in need and for physicians to act professionally and ethically. Hence, the law should be aligned with the patient's needs; if the patient's families and professional caregivers do not avail of it, it does not serve the purpose. Thus, the Indian Society of Critical Care Medicine (ISCCM) sought clarification to facilitate the actual working of the directions to circumvent the insurmountable obstacles posed and to make procedural amendments to the existing directives/guidelines issued by the Supreme Court in 2018.³¹ The *Common Cause* judgement in 2018³² recommended a process that was obviously unworkable on the ground. Indeed, there have been none to avail of the provisions through the defined process. This necessitated the ISCCM appeal for the procedural simplification. In the latter judgement that followed in January 2023,³³ significant simplification was achieved, yet it continues to be cumbersome, although now workable.

The modified Supreme Court directives

The decision to pursue this renewed approach appears to be motivated by the practical challenges of implementing the directions outlined in the previous judgement. Numerous doctors have expressed these difficulties, highlighting the need for the Court to reassess the guidelines and devise a more effective mechanism to achieve the intended objectives outlined in its previous ruling.³⁴ As a result, the Court deemed it necessary to revisit the directions and revise the guidelines for patients with and without AD to ensure the effective implementation of its objectives.³⁵ What followed was the procedural simplification

29. Ibid., para 191.

30. Ibid., pp. 170–186.

31. *Common Cause (A Regd. Society) v. Union of India & Another* [2023] INSC 77, para 3.

32. *Common Cause* (n 9).

33. *Common Cause* (n 31).

34. Ibid., para 5.

35. Ibid., para 5.

of the process of executing a valid AD and also for treatment-limiting (passive euthanasia) decisions. The steps requiring bureaucratic and judicial oversight were removed.

The missed opportunity in *Aruna Ramachandra Shanbaug v. Union of India*³⁶

The *Aruna Shanbaug* case marked a pivotal moment in the legal and ethical discourse on passive euthanasia in India; the judgement and the discussion surrounding it were limited in scope and did not entirely align with patient-centric considerations.

The petition filed by journalist Pinki Virani sought permission for passive euthanasia to end Shanbaug's suffering, but the scope of the judgement was primarily focused on Shanbaug's medical condition, persistent vegetative state (PVS) and the procedural question of passive euthanasia as it related to the right to life rather than a nuanced analysis of the patient's rights to autonomy and dignity.³⁷ The judgement concluded that she could not be considered for passive euthanasia because her caregivers (nurses) at KEM Hospital opposed it. It did not fully explore the nuances of end-of-life care from the patient-centric perspective but rather confined its analysis to specific medical and legal considerations around PVS.³⁸ This narrow focus on the hospital's views, rather than considering what Aruna might have wanted (if she had been able to express it), reflected a limited terms of reference of the judgement.

One of the most unusual aspects of the judgement is the weight given to the perspective of KEM Hospital's nursing staff and administrators.³⁹ It shifted the focus away from patient autonomy and self-determination, which should have been central to any discussion on treatment-limiting decisions. This raises an important ethical question: Should the decision have rested on the preferences of the caregivers, or should the court have given greater weight to the idea of the unspoken patient's needs? Even though Aruna could not express her own wishes, the judgement could have been an opportunity to foreground the importance of a patient's right to self-determination, even in PVS cases. Instead, the wishes of the medical staff seemed to outweigh any hypothetical consideration of what Aruna herself might have wanted had she been able to decide, thereby limiting the scope for a rights-based dialogue about passive euthanasia.

While the petition to withdraw life support for Aruna Shanbaug was ultimately dismissed, the Supreme Court's judgement legalized passive euthanasia, that is withdrawal and withholding of life support in principle in India, however, adding the challenging condition of a high court's approval.⁴⁰ This case illustrated a paradoxical outcome – wherein passive euthanasia was legalized, but the onerous procedure put it out of reach for the average patient. Thus, the judgement was conceptually significant but procedurally

36. Aruna (n 3).

37. Ibid., para 2.

38. Ibid., para 126.

39. Ibid.

40. Ibid., para 132 and 138.

unworkable, as it did not place the patient at the heart of the decision-making process, ultimately undermining the broader goal of ensuring dignified death.

Critical analysis of the 2023 modifications

The 2023 judgement of the Supreme Court of India, which modified the guidelines related to AD and reaffirmed the right to die with dignity as a fundamental right, represents a significant development in end-of-life care in India.⁴¹ While the judgement advances patient autonomy, it raises critical concerns when analysed through various perspectives, especially with respect to aligning with international norms, safeguarding patient rights, and procedural hurdles.

Procedural blocks favouring oversight over medical judgement

In the 2018 judgement, there was a three-tier process for decision-making: a primary board in the hospital, another board by the district collector, and, finally, verification by the jurisdictional magistrate of the first class.⁴² Unsurprisingly, this onerous procedure was never utilized.

The multiple layers of approval required before an AD can be executed introduce several procedural hurdles. However, in the 2023 modified directives, judicial intervention has been excluded.⁴³ However, it still requires reviews by two independent medical boards, one after another. This creates a significant delay, especially when dealing with terminally ill patients where time is of the essence. This contrasts with international models such as those in the United States⁴⁴ and France,⁴⁵ which allow families and medical professionals to make timely decisions without requiring multiple layers of decision-making or judicial oversight. They recognize that end-of-life treatment limitation is essentially a medical decision arrived at through a shared decision-making process with the incapacitated patient's surrogate(s). India's procedure is slow, biased towards preserving life regardless of the quality of that life, and burdensome to execute.

41. Common Cause (n 31), para 6.

42. Common Cause (n 9), para 191.

43. Common Cause (n 31), para 6.

44. Robert D. Truog, Margaret L. Campbell, J. Randall Curtis, Curtis E. Haas, John M. Luce, Gordon D. Rubenfeld, Cynda Hylton Rushton, David C. Kaufman, and American Academy of Critical Care Medicine, 'Recommendations for End-of-Life Care in the Intensive Care Unit: A Consensus Statement by the American College of Critical Care Medicine', *Critical Care Medicine* 36(3) (2008), pp. 953–963.

45. Olivier Lesieur, Maxime Leloup, Frédéric Gonzalez, Marie-France Mamzer, and EPILAT Study Group. 'Withholding or Withdrawal of Treatment under French Rules: A Study Performed in 43 Intensive Care Units', *Ann Intensive Care* 5(1) (2015), p. 56.

In principle alignment with global norms, but procedurally not aligned

While the principle behind the judgement is consistent with the global shift towards recognizing patient autonomy at the end of life, the procedure though simplified from the 2018 judgement remains unnecessarily cumbersome. Many developed nations have clear, often simpler, streamlined procedures for implementing these rights, requiring only the consent of healthcare providers and immediate family, respecting patient autonomy without unnecessary bureaucratic delays. This procedural misalignment with global practices makes the Indian approach inefficient and prone to delays, undermining the very purpose of enabling dignified death through timely decision-making.

Undermining patient rights and the fiduciary relationship

One of the key concerns is that the judgement undermines the very objective it sets out to achieve: safeguarding patient rights. The fiduciary relationship between doctors and patients, which is built on trust, is diluted by this highly procedural framework. By imposing multiple layers of approval, the judgement diminishes the treating physician's role in facilitating end-of-life care decisions, placing undue emphasis on legal and administrative procedures. The concern for criminal intent, which the Court seeks to address through such procedures, reflects a lack of faith in medical professionals. There are hardly any case laws in India and elsewhere about misuse of the provisions laid down to safeguard patient rights, especially in end-of-life care. This further complicates the doctor's role in respecting patient wishes. The fear of potential legal liability can deter doctors from honouring AD, even if they align with the patient's expressed desires. This over-regulation does little to prevent abuse but instead creates unnecessary distrust in what is essentially a fiduciary more than a transactional relationship.

Moving away from paternalistic notions to shared decision-making

The judgement reflects an attempt to shift towards shared decision-making, wherein patients are more involved in their own end-of-life care decisions. This aligns with modern medical ethics, which emphasize patient autonomy, informed consent, and collaborative decision-making. However, while the intention to promote shared decision-making is clear, the judgement does not fully support this transition in practice. The shared decision-making process should ideally be a conversation between the patient, their family, and the treating physician and should not need the intervention of other physicians not directly caring for the patient. Autonomy, although an important ethical principle in medical practice, must be combined with the physician's duties of care, that is to act in beneficence and non-maleficence. Instead of empowering the patient and their immediate healthcare team, the decision-making process becomes diffuse, delaying critical interventions and disempowering patients in what should be a private and personal decision. By imposing multiple layers, the Court indirectly reinstates a form of paternalism

where operative processes laid down by the court, rather than the doctor or the patient, ultimately determine life-and-death decisions.

A practice in evolution, raising more questions than answers

The concept of the right to die with dignity and the use of ADs in India is still in its evolutionary phase. While the recognition of living wills is a positive step, the difficulties in implementation raise more questions than they provide answers. How will these complex procedures be applied in rural or underserved areas with limited access to medical boards? Will patients without access to medical expertise be at a disadvantage? The complex process, coupled with the lack of clear guidelines for healthcare providers, raises concerns about the practical applicability of living wills in India. Furthermore, the judgement has not addressed how conflicts between family members or between patients and healthcare providers will be resolved, leaving many important questions unanswered. The complexity of the current process also raises questions about its accessibility. For a vast majority of Indians, particularly those in rural areas, navigating the legal requirements for enforcing ADs may prove too daunting, making it a privilege available only to certain people. This could create a form of inequity where only a small portion of the population can realistically exercise their right to die with dignity. These issues suggest that while the law has made progress, the execution remains deeply flawed. In addition, while the judgement seeks to prevent misuse and abuse, it paradoxically creates a system where procedural obstacles make it nearly impossible for patients to access the very rights the judgement claims to protect.

The impact of the judgement and the further developments

The Ministry of Health and Family Welfare (MoHFW), Government of India (GoI) issued guidelines on ‘Guidelines for Intensive Care Unit Admission and Discharge Criteria’ in December 2023.⁴⁶ It stresses that the criteria for admitting a patient to the ICU should be based on weighing the possibilities of benefit versus harm from critical care and not if an end-of-life treatment limitation decision is already made. The MoHFW, GoI has also issued draft guidelines titled ‘The Guidelines for Withdrawal of Life Support in Terminally Ill Patients’ in September 2024 and sought comments from experts and the public; we are awaiting the notification of the finalized guidelines.⁴⁷ Isra Black, in a

46. ‘Guidelines for Intensive Care Unit Admission and Discharge Criteria’, Ministry of Health and Family Welfare, Government of India, December 2023, available at <https://dghs.gov.in/Uploaddata/Final%20Guidelines%20for%20ICU%20Admission%20and%20Discharge%20Criteria%2023.12.2023.pdf> (accessed 9 July 2024).

47. ‘Guidelines for Withdrawal of Life Support in Terminally Ill Patients’, Ministry of Health and Family Welfare, Government of India, September 2024, available at <https://dghs.gov.in/Uploaddata/Guidelines%20for%20withdrawal%20of%20Life%20Support%2014624.pdf> (accessed 30 November 2024).

recent critique of the draft guidelines,⁴⁸ acknowledges the difficulties in translating the recommendations in the amended *Common Cause* judgement⁴⁹ by the bedside.

Report of the Law Commission of India

In the 2012 report on passive euthanasia, after studying the matter compared to corresponding international laws and cases, the Commission drafted a bill for the same,⁵⁰ titled ‘Medical Treatment of Terminally Ill Patients (Protection of Patients and Medical Practitioners)’, which is an amendment to the 2006 draft bill⁵¹ in light of developments due to the *Aruna Shanbaug*’s case⁵² and is yet to see the light of the day as a legislation.

Conclusion

While the 2018 judgement, followed by amendments in the 2023 judgments of the Supreme Court, is a significant step forward in recognizing the right to die with dignity, it falls short of aligning with global practices in both spirit and execution. The failure to fully trust the medical profession or surrogate acting in the patient’s best interests undermines the broader aim of safeguarding patient rights. Shared decision-making is hindered by overly cautious, multilayered decision-making that places unnecessary roadblocks in the way of patients and doctors alike. To be truly effective, the legal framework for end-of-life care in India must be further refined, with a focus on simplifying procedures and empowering healthcare providers, as well as families, to ensure that patient rights are safeguarded without needless delay. This is crucial for aligning India’s approach with global standards and ensuring that the right to die with dignity becomes a practical reality rather than a theoretical ideal.

Author contributions

Conceptualization was done by RIJ and RKM. RIJ, SK, and GPD did a literature search and prepared the original manuscript draft. RKM critically reviewed and edited the manuscript. All the authors had access to the manuscript and agreed to submit the same for publication.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

48. ‘Foregoing Life Support’, Isra Black, November 2024, available at <https://indialegalive.com/magazine/foregoing-life-support-terminally-ill-patients-ministry-of-health-family-welfare/> (accessed 6 January 2025).

49. *Common Cause* (n 31).

50. Cf (n 23).

51. Law Commission of India, *Medical Treatment to Terminally Ill Patients (Protection of Patients and Medical Practitioners)* (Law Com Rep No 196, 2006).

52. *Aruna* (n 3).

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

ORCID iDs

Ranjit I. James  <https://orcid.org/0000-0001-7710-0673>

Raj K. Mani  <https://orcid.org/0000-0003-4759-8233>