ADVANCE MEDICAL DIRECTIVES AND ARTICLE 21: BALANCING INDIVIDUAL AUTONOMY AND PROCEDURAL SAFEGUARDS

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ABSTRACT

The concept of individual autonomy in end-of-life decision making has been significantly expanded through the recognition of the right to die with dignity under Article 21 of the Indian Constitution. The Supreme Court has recognized Advance Medical Directives (AMDs) as a means for people to exercise their autonomy regarding life-sustaining medical treatment in the event of future incapacity, particularly in Common Cause v. Union of India (2018) and in its subsequent 2023 modification of the guidelines. However, the practical use of AMDs raises questions regarding the balance between procedural safeguards and individual choice. The evolution of autonomy and the right to die with dignity under Article 21 is examined, with an emphasis on the evolving precedent regarding Advance Medical Directives. It examines whether the procedural protections governing AMDs sufficiently shield people from coercion and misuse without creating unnecessary obstacles to the exercise of autonomy. The study also examines the institutional and legal issues surrounding the use of AMDs and discusses the need for a clearer, more accessible framework. The analysis also takes into account developments in Harish Rana v. Union of India (2026), specifically regarding the role of medical boards and the removal of life-sustaining care. It contends that although protections are necessary to preserve the sanctity of life, they must be reasonable and support the fundamental guarantees of autonomy and dignity under Article 21, rather than destroy them.

Keywords: Advance Medical Directives, Article 21, Right to die with Dignity, Individual Autonomy, Procedural safeguards

INTRODUCTION

The right to life and personal liberty is enshrined in Article 21 of the Indian Constitution[1]. Yet, by way of judicial interpretation, the scope of the provision has been broadened from a simple guarantee of physical existence to one that also encompasses dignity, privacy, and autonomy, as well as freedom to take very personal decisions. A case in point is the emergence of the right to die with dignity when faced with terminal illness or end-of-life medical care. To give effect to individual autonomy in such a matter, there is the advance medical directive (AMD), or living will. This instrument permits a person of sound mind to put his or her treatment preferences on record for a time when they may no longer be able to do so. In this way, an autonomous decision made today can direct medical practice during a future period of incapacity.

In its 2018 judgment in Common Cause v. Union of India[2]. The Supreme Court gave constitutional standing to AMDs. The court was clear that the right to die with dignity is an aspect of Article 21 and that a competent individual may refuse life– sustaining treatment and put an advance directive in place. At the same time, it laid down safeguards to see that any such step is taken voluntarily and without coercion. The original rules, however, were replete with procedural demands that were difficult to implement. The Supreme Court saw fit to alter these in 2023 to make the process more workable. Then came Harish Rana v. Union of India in 2026[3], which provided further clarity on the withdrawal of life support, the role of medical boards and palliative care, and what is in the best interests of an incapacitated patient. Noting the need for comprehensive legislation to bring certainty to the matter, the court reiterated the law as it stood in that case.

Consequently, the question is not so much whether AMDs are constitutionally valid; the substance of the issue lies in whether the procedural protections in place manage to balance the protection of the vulnerable with the meaningful exercise of Autonomy under Article 21. This paper examines the balance and asks whether the current judicial framework calls for additional reform.

[1] INDIA CONST. art.21.
[2] Common Cause (A regd. Society) v. Union of India (2018) 5 SCC 1 (India)
[3] Harish Rana v. Union of India, 2026 INSC 222 (India)

BACKGROUND

The law on end-of-life decisions in India has, for the most part, been shaped by judicial interpretation of Article 21. The evolution can be traced back to the case of P. Rathinam v. Union of India in 1994[4], where the Supreme Court first recognized the right to die under Article 21. This position was later set aside in Gian Kaur v. State of Punjab[5]. The court acknowledged the difference between purposefully ending one's life and the idea of dying with dignity as part of the natural process of death, even if it rejected a general right to die.

In the case of Aruna Ramachandra Shanbaug v. Union of India[6], the Supreme Court re-examined the matter and acknowledged passive euthanasia under strictly regulated conditions. The ruling marked a significant step towards acknowledging the importance of the medical economy and dignity in end–of–life decisions. Common cause v. the Union of India[7] was the most important constitutional development. The court acknowledged that a competent individual may exercise an AMD outlining their preferences for future medical care in the case of incapacity and that they have the right to refuse medical treatment, as held by the constitutional bench, which stated that Article 21 right to life includes the right to die with dignity. The ruling linked this autonomy to the rights to privacy and dignity guaranteed by the Constitution.

However, the court concurrently established extensive safeguards controlling the development and application of AMDs. These contained specifications for witnesses, verification, medical evaluation, and medical board involvement. The goal was to prevent coercion or abuse of vulnerable individuals and to guarantee that the decision was genuine and voluntary. In 2023, the Supreme Court changed the process due to practical difficulties with the initial framework. The changes aimed to maintain protections while reducing procedural barriers. The framework was further simplified and clarified by the subsequent Harish Rana ruling in 2026. The court explicitly examined the definition of the "best interests of the patient" standard, the regulation of the medical boards, the shift from curative to palliative and end-of-life care, and whether clinically assisted hydration and nutrition qualify as medical treatment. Hence, the growth of the law demonstrates an ongoing effort to balance the state's duty to protect life with an

[4] P. Rathinam v. Union of India, (1994) 3 SCC 394 (India)
[5] Gian Kaur v. State of Punjab, (1996) 2 SCC 648 (India)
[6] Aruna Ramachandra Shanbaug v. Union of India, (2011) 4 SCC 454 (India)
[7] Common Cause (A regd. Society) v. Union of India (2018) 5 SCC 1 (India)

individual's rights to dignity and autonomy.

LITERATURE REVIEW

The Existing literature on Advance Medical Directives in India concentrates on the connection between end-of-life decision-making, individual autonomy, and dignity. The living will, a concept put forward by Luis Kutner (1969)[8], allows a person of sound mind to set out his or her wishes regarding life-sustaining care in the event of later incapacity; this is consistent with the common-law view of an individual's right over his or her own body. In India, Article 21 has come to provide the constitutional basis for this, notably through the privacy and dignity principles affirmed in Justice K.S. Puttaswamy v. Union of India. There has been considerable evolution in Indian case law on the subject. While P. Rathinam v. Union of India (1994) at first acknowledged a right to die, Gian Kaur v. State of Punjab (1996) put an end to that, though it did draw a line between suicide and the natural process of dying with dignity. The Supreme Court later opened the door to passive euthanasia with proper safeguards in Aruna Ramachandra Shanbaug v. Union of India (2011). That trajectory culminated in Common Cause v. Union of India (2018), in which AMDs were granted legal standing as an extension of the right to die with dignity under Article 21, and the Court modified the guidelines in 2023 for practical reasons. The 2026 Harish Rana v. Union of India case has since reinforced this position, holding that clinically assisted nutrition and hydration can be treated as medical treatment and withdrawn when warranted.

The evolution of the right to die with dignity is examined by Khanna and Kaur[9] in their study on passive euthanasia and Advance Medical Directives. They also draw attention to the legal issues surrounding an individual's exercise of choice regarding life-sustaining care. Their analysis shows that while acknowledging AMDs is a significant step toward respecting patient autonomy, there are still issues with their implementation. The literature on Advanced Care Planning in India emphasizes that successful implementation is not ensured by legislative recognition alone[10]. According to a 2023 narrative assessment, despite AMD's constitutional recognition in 2018, its actual application was restricted until 2023, when procedural

[8] Kutner, Due Process of Euthanasia: The Living Will, a Proposal, 44 IND. L.J. 539 (1969)
[9] P. Khanna & P. Kaur, Legalization of Passive Euthanasia in India: Right to Die with Dignity with Special Reference to "Advance Medical Directive," 1 CENT. U. KASHMIR L. REV. 100 (2021)
[10] R. Gursahani et al., Advance Care Planning in India: Current Status and Future Directions—A Short Narrative Review, 180 ZEITSCHRIFT FÜR EVIDENZ, FORTBILDUNG UND QUALITÄT IM GESUNDHEITSWESEN 64 (2023)

adjustments were implemented. Inadequate awareness, health and death literacy, and a lack of palliative care infrastructure are further identified as major obstacles to the successful execution of advance care planning in India. Further, James et al investigate the evolution of end-of-life care in India as well as the ethical and legal implications of the Common Cause judgment. The ongoing conflict between upholding advance directives and ensuring adequate protection for at-risk patients is highlighted by their analysis. Understanding how constitutional recognition of autonomy functions within the larger framework of end-of-life decision-making is made easier by this literature[11]. Butola and Gursahani[12] also stress the significance of "death literacy" and understanding in helping people interact with advance care planning in a meaningful way. According to their research, if people are to exercise their autonomy effectively, legal recognition of AMDs must be complemented by increased institutional support and public awareness.

Further, procedural safeguards are another significant barrier to the actual exercise of autonomy, according to the literature. According to Mani et al.[13] The process initially developed under the common-cause case was excessively complex, especially for decisions affecting individuals who have lost the ability to make their own judgments. The authors noted that the 2023 changes were necessary to make end-of-life decision-making more practical while maintaining ethical and legal protections, and that the procedural restrictions posed challenges in clinical practice. The need for a more precise and useful institutional structure has been the subject of more recent research. To implement Advanced Care Planning and MDs in India, Damani et al. (2025) propose a systematic 12-step roadmap that emphasizes decision-making capacity, cultural considerations, legal compliance, palliative care, and practical implementation. This implies that the development of accessible processes that enable the actual exercise of autonomy is just as important to the future of AMDs as the recognition of auton The ongoing development of end-of-life in India is further evidenced by recent literature published after Harish Rana v. Union of India. According to Timms and Govind (2026), the ruling offers further clarity on the role of medical decision-making at the end of life and the cessation of life-sustaining care. According to this growing body of research, the main issue is the balance of autonomy with protections against abuse, coercion, and improper treatment

[11] R. I. James et al., Common Cause (A Regd. Soc'y) v. Union of India [2018] INSC 223: End-of-Life Care in India, 25 MED. L. INT'L 136 (2025)
[12] S. Butola & R. Gursahani, Advance Care Planning and the Ethical Obligation of Death Literacy as a Public Health Initiative in India, 9 INDIAN J. MED. ETHICS 308 (2024).
[13] R. K. Mani, S. Simha & R. Gursahani, Simplified Legal Procedure for End-of-Life Decisions in India: A New Dawn in the Care of the Dying? 27 INDIAN J. CRITICAL CARE MED. 374 (2023)

withdrawal rather than just whether autonomy should be recognized.

The constitutional recognition of the right to die with dignity and the significance of patient autonomy are covered in great detail in the literature currently in publication, but relatively little focus is placed on whether the procedural safeguards governing AMDs try to balance autonomy with protections against abuse and coercion. Furthermore, it is necessary to assess whether the current legislative framework is sufficiently accessible to enable successful implementation in light of the recent developments following the 2023 procedural revisions. By analyzing the connection between Article 21, individual autonomy, procedural safeguards, and the actual use of AMDs in India, this research aims to close this gap.

RESEARCH OBJECTIVES

1) To examine the evolution of Article 21 constitutionally and judicially, to include individual autonomy and the right to die with dignity, with a focus on Advance Medical Directives.

2) To evaluate whether the procedural safeguards controlling the implementation and execution of Advance Medical Directives sufficiently balance individual autonomy and protection against misuse and coercion.

3) To determine the practical and legal obstacles to the implementation of AMDs and offer changes that can improve the framework's accessibility while maintaining sufficient protections.

RESEARCH OUTCOME AND ANALYSIS

Constitutional Development of the Right to Die with Dignity and Individual Autonomy under Article 21.

Article 21 has gradually expanded from a simple shield for physical existence to a guarantee of personal liberty and autonomy, thereby shaping India's constitutional understanding of the right to die with dignity. The Supreme Court first recognized this in P. Rathinam v. Union of India[14], holding that the right to life encompassed a negative right not to have to continue living.

[14] P. Rathinam v. Union of India, (1994) 3 SCC 394 (India)

That view did not hold; it was put to rest by the Constitution Bench in Gian Kaur v. State of Punjab (1996), which made clear that Article 21 is not a license to end one's life. Yet the Court in Gian Kaur left room for the notion that dignity could pertain to the very last phase of a natural life when death is inevitable.

The line drawn in Gian Kaur would prove pivotal for what followed. By the time of Aruna Ramachandra Shanbaug v. Union of India (2011), the Supreme Court had come to accept passive euthanasia in tightly regulated situations. It was held that upholding the sanctity of life does not mean every medical measure must be pursued if there is no prospect of a meaningful recovery. In effect, the Court began to separate the active causing of death from the decision to let nature take its course by withdrawing life support.

Justice K.S. Puttaswamy v. Union of India[15] added further weight to the case for individual autonomy. With the Supreme Court linking privacy to dignity, individual decision-making, and bodily integrity under Article 21, it became evident that choices about one's health and medical care are of a deeply personal nature. Knowledge is important in medical treatment because decisions about one's body, medical intervention, and personal health are deeply personal. Therefore, autonomy provides a crucial constitutional foundation for enabling individuals to determine their medical preferences in advance.

This evolution found its apex in Common Cause v. Union of India (2018). A Constitution Bench there enshrined the right to die with dignity as fundamental and recognized Advance Medical Directives, or Living Wills. An AMD is significant because it allows a competent person to make known his or her future wishes, ensuring those preferences are not simply set aside should capacity be lost later on. The value of an AMD is in preserving choice after the fact, not in conferring an unbridled right to death. The protection is one of autonomy in refusing unwanted treatment, not a right to intentionally bring about death. Therefore, the constitutional significance of AMDs is found in safeguarding an individual's freedom to refuse unpleasant medical treatment rather than establishing the right to die. The distinction is crucial because, unlike a generic right to intentionally cause death, the constitutional protection is related to autonomy in medical decision-making. An AMD keeps an individual's previously states wish in effect and keeps them from being totally superseded just because the person has now lost

[15] Justice K.S. Puttaswamy (Retd.) v. Union of India, (2017) 10 SCC 1 (India)

the ability to make decisions

More recently, the Supreme Court has seen fit to adjust the Common Cause guidelines, noting in 2023 that they were difficult to implement. The aim was to streamline the process without compromising on the safeguards needed to verify that the directive was voluntary and authentic. The jurisprudence was further shaped in Harish Rana v. Union of India (2026), which once again underscored the primacy of patient autonomy and dignity at the end of life and put the matter of clinically assisted nutrition and hydration in proper legal perspective.

Therefore, through this judicial record, Article 21 has been transformed from a narrow defense against the loss of life into a framework for the quality, autonomy, and dignity associated with death. Advance Medical Directives are the means by which that autonomy can continue to function even when an individual is unable to communicate their wishes.

Balancing Individual Autonomy and Procedural Safeguards in the Execution and Implementation of Advance Medical Directives

Advance Medical Directives are founded on the principle of individual autonomy, yet to put them into effect without restriction is to invite the possibility of coercion, manipulation, or a misreading of the directive's intent. Given that an end-of-life decision is one from which there is no turning back, some form of safeguard is called for to be sure the directive is, in fact, the voluntary and informed will of the person concerned. The law has to strike a balance between two things: honoring what the individual has put on record and making certain those wishes are authentic and medically sound in light of the circumstances at hand.

In the Common Cause judgment, the Court set out procedural rules for AMDs with this equilibrium in mind. For a directive to stand, the individual must be of sound mind and able to grasp what is at stake; it must be made free of any undue influence and leave no doubt as to the wishes regarding the treatment in question. This is necessary protection, since a piece of paper alone does not prove a genuine choice.

Then there is the matter of medical safeguards during implementation. Because an AMD is meant for future contingencies, the prevailing medical situation must be considered. It falls to the medical boards to determine whether the patient's condition is as the directive envisaged and whether withholding or withdrawing care is proper from both legal and medical

standpoints. In this way, the document is not simply followed as a matter of course. But such protections can also be a source of difficulty. The Supreme Court's original framework was faulted for its procedural complexity, not least for the part played by the judiciary and top-tier specialists[16]. These practical realities prompted a change in 2023, with the Court simplifying the authentication process and the way medical boards operate. One sees here a tension in the law: while safeguards are needed to defend autonomy, too many of them can make its exercise impossible.

This can be described as something similar to a paradox. A procedure put in place for the vulnerable can become an obstacle if it demands layers of institutional and medical sign-off, a problem that is only magnified where specialist infrastructure is thin on the ground. Where the right practitioners cannot be found, a perfectly valid AMD may be obstructed. That is a constitutional issue under Article 21; the enjoyment of a right ought not to hinge on the presence of sophisticated institutions. Time is also a factor in these matters as end-of-life decisions are often time-sensitive. Unwarranted administrative holdups can mean a patient is subjected to medical intervention he or she had expressly ruled out, thereby undermining the very autonomy it is supposed to uphold.

The Harish Rana ruling of 2026 is the latest effort to put this right. The Supreme Court has retained medical oversight but has clarified the boards' role and reduced judicial involvement where the medical prerequisites and safeguards are in place. It is an acknowledgment that medical decisions are best left to medical mechanisms, with the courts standing by should a disagreement or failure of process arise.

Ultimately, proportionality is the key to maintaining the balance between safeguards and autonomy. Safeguards must confirm that the AMD is voluntary, informed, and applicable, but once that is done, the procedure should not supplant the individual's choice with institutional fiat. The aim is to verify autonomy, not to take its place.

Legal and Institutional Framework for Effective Implementation of Advance Medical Directives in India

Despite the Supreme Court's recognition that Advance Medical Directives are a matter of considerable constitutional import, the system as it stands remains heavily reliant on guidelines

[16] Common Cause (A Regd. Soc'y) v. Union of India, 2023 INSC 77 (India)

set by the judiciary. This reliance raises issues of uniformity and long-term institutional accountability. The Court has been detailed in its directions under its constitutional authority, yet judicial pronouncements are no substitute for a thorough legislative scheme regarding end-of-life medical decisions.

There is a distinction to be made with the Mental Healthcare Act of 2017[17], which gives statutory standing to advance directives in the realm of mental health. But where life-sustaining treatment at the end of life is concerned, one must look to the framework established by Common Cause and later court rulings. Without an all-encompassing piece of legislation for end-of-life care, there is bound to be uncertainty about what is required of patients, their families, doctors, and the various boards that oversee them.

A proper statute would establish the procedure for AMDs, from execution to preservation, and specify when life-sustaining measures may be withdrawn. That kind of clarity dispels institutional ambiguity and makes the right more predictable. It is also a question of legal protection for the practitioner. A doctor may be left in doubt over the consequences of heeding an AMD; a clear law would shield those who act in good faith and follow the rules, while still holding them to account for any negligence or misuse. Then there is the matter of accessibility. An individual may have the legal entitlement to put an AMD in place, but if it is difficult to implement when the time comes, the constitutional right is not fully realized. The law ought to provide straightforward methods for recording and safeguarding such documents.

The framework needs to make sense of the link between palliative care and the withdrawal of treatment. As Harish Rana has pointed out, the right to die with dignity is tied to appropriate end-of-life care. Withdrawing support should not equate to abandoning the patient; the aim is to let nature take its course whilst managing pain and discomfort. Palliative care must be seen as an integral part of dignified decision-making in any new statute.

The need of setting advance judgements within a well-defined legislative framework is further illustrated by comparative legal methods. Countries such as the United States and the United Kingdom need to recognize the merits of a legislative framework for advanced healthcare decisions. Their models offer clarity for institutions and patients alike. India cannot simply copy them, given the differences in our legal and healthcare systems, but they show why

[17] Mental Healthcare Act, No. 10 of 2017, § 5, Acts of Parliament, 2017 (India)

accessible procedures are necessary.

Accordingly, whatever the Indian framework becomes in the future should do more than codify what the courts have already said. It has to deal with the realities of implementation. By ensuring that autonomy is protected, doctors have certainty and remain proportionate, that medical boards can work efficiently, and that patients have access to the palliative care they need, the system can give practical meaning to the constitutional right to die with dignity.

CONCLUSION AND RECOMMENDATIONS

India's approach to Advance Medical Directives has undergone a marked evolution, one that speaks to a changed constitutional reading of Article 21. The Supreme Court has made it plain through its jurisprudence, in cases ranging from Gian Kaur and Aruna Shanbaug to Common Cause and Harish Rana, that the right to life is inextricably linked to personal autonomy and dignity. To be sure, acknowledging the right to die with dignity is not the same as endorsing an unfettered right to end one's life; it is about safeguarding an individual's ability to make informed choices on matters of unwanted medical intervention, especially where future incapacity would otherwise silence those wishes.

Yet procedural safeguards are called for to shield the vulnerable from any form of coercion or misuse, provided they do not become overbearing. The experience with the initial Common Cause framework and the 2023 revisions has been instructive in this regard: too much red tape can erode the very autonomy AMDs are meant to serve. For all that, there is still the matter of a missing statutory framework. When one must rely chiefly on the courts, it leaves room for doubt as to how guidelines are to be followed and who is responsible for what, not to mention the protection of the medical profession. What is needed is a mechanism that is both uniform and accessible so that the constitutional right can be put into practice.

A case for comprehensive legislation on end-of-life care and AMDs to codify necessary protections without making the authentication and execution process overly complex xouls. It would bring clarity to the duties of hospitals, treating physicians, and nominated representatives alike. A dependable system for the registration and storage of directives would also be valuable; digital records would ensure a valid document is at hand when needed without compromising confidentiality, sparing the patient's family the trouble of locating physical documents at a critical juncture.

At the same time, doctors who follow the law in good faith ought to be given the legal cover they are due. This would go some way towards curbing defensive medicine while holding practitioners to account for negligence. And it is imperative that the withholding of life support is not tantamount to abandonment. Palliative measures for pain and symptom control should be part of the package.

Therefore, the aim of India's framework should be to give substance to the autonomy enshrined in Article 21, not just to validate a piece of paper. With a structure that offers institutional clarity, upholds dignity, and makes palliative care available, the right to die with dignity will be a genuine constitutional guarantee rather than something that exists only in principle.

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