AT THE EDGE OF LIFE: WHEN LAW, MEDICINE, AND MORALITY CONVERGE

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Introduction

The law, in its most assured posture, proclaims certainty. It classifies, commands, restrains, and sanctions with the confidence of an authority that presumes itself both rational and complete. Yet, at the fringes of its dominion, there persists a troubling frontier, one where life no longer follows its natural course but is instead prolonged through artificial means, sustained by instruments rather than instinct. Here, medicine intervenes with technical precision, morality raises uneasy questions, and the law, stripped of its declaratory force, hesitates in visible uncertainty. In these quiet yet decisive spaces, hospital wards and courtrooms alike, a deeper contradiction reveals itself: the preservation of life, once upheld as an unquestioned imperative, becomes contingent in its application. Not because life diminishes in worth, but because dignity, long suppressed beneath the weight of survival, begins to assert itself as an equal, and perhaps superior, juridical claim.

I. The Indian Position: Law Learning to Hesitate

India's legal engagement with euthanasia has been neither swift nor assured. It has unfolded through judicial introspection rather than legislative conviction, halting, cautious, and persistently shadowed by moral hesitation. The decisive shift emerged in Common Cause v. Union of India (2018)[1], where the Supreme Court formally recognised passive euthanasia and accorded legal validity to living wills. Yet, even in recognition, there was restraint. The Court did not affirm a right to die; it merely conceded that the State cannot indefinitely impose life where dignity has receded.[2]

This position was foreshadowed in Aruna Ramachandra Shanbaug v. Union of India (2011).[3] There, confronted with a life suspended in permanence yet devoid of consciousness, the Court

[1] *Common Cause v. Union of India*, (2018) 5 SCC 1.
[2] *Id.* at ¶¶ 198-201.
[3] *Aruna Ramachandra Shanbaug v. Union of India*, (2011) 4 SCC 454.

permitted passive euthanasia under strict judicial oversight.[4] It refused active intervention, but acknowledged, albeit cautiously, the legitimacy of withdrawal.

The present framework rests upon three structured pillars[5]: autonomy through advance directives, medical verification by competent professionals, and layered oversight to guard against misuse. Yet beneath this architecture lies a visible unease. The law hesitates to trust finality. It insists on repetition, multiple certifications, procedural barriers, prolonged scrutiny as though delay itself were a moral virtue, and hesitation the last defence against irreversible error.

II. Foreign Jurisdictions: Structured Acceptance Without Abandonment

In contrast, jurisdictions such as the United Kingdom and the Netherlands reflect a more settled, though by no means untroubled, legal posture, one that tempers moral anxiety with institutional clarity.

In the United Kingdom, active euthanasia remains prohibited. Yet, in Airedale NHS Trust v. Bland (1993)[6], the House of Lords drew a careful but decisive distinction: the withdrawal of life-sustaining treatment, in cases of irreversible unconsciousness, does not constitute an act of killing. It is, rather, a juridical recognition that continued intervention ceases to serve the patient's best interests. The law, here, refrains from authorizing death; it acknowledges the futility of prolonging life devoid of recovery.

The Netherlands, by contrast, adopts a more permissive yet tightly regulated framework. Under the Termination of Life on Request and Assisted Suicide Act (2002)[7], both passive and active euthanasia are conditionally lawful. However, this apparent liberalism is circumscribed by rigorous safeguards: the patient's suffering must be unbearable and without prospect of improvement; the request must be voluntary, informed, and enduring; and independent medical assessments must corroborate the diagnosis. Far from casual, the system is procedurally exacting each case documented, reviewed, and retrospectively scrutinized. Autonomy exists, but never in isolation; it is continuously supervised.

[4] *Id.* at ¶¶ 101-104.
[5] *Common Cause*, (2018) 5 SCC at ¶¶ 192-195.
[6] *Airedale NHS Trust v. Bland*, [1993] AC 789 (HL).
[7] Termination of Life on Request and Assisted Suicide (Review Procedures) Act, 2002 (Neth.).

Across these jurisdictions, a consistent principle emerges: passive euthanasia is not justified by a desire for death, but by the absence of any realistic prospect of recovery. Yet, even this foundation is unsettled. Medicine, as practitioners concede, operates in probabilities, not certainties. Rare recoveries from prolonged unconscious states persist as disquieting exceptions reminding both law and medicine that where doubt endures, finality remains profoundly contested.

This uncertainty explains the law's persistent insistence on delay, verification, and layered scrutiny. It also reveals the silent burden imposed upon those compelled to decide families, physicians, and, at times, courts each navigating a space where certainty is absent but consequence is final.

The concept of brain death seeks to resolve this ambiguity. Medically and legally, it denotes the irreversible cessation of all brain activity: the body may continue through mechanical support, yet the person, as a conscious and sentient entity, has ceased to exist. In India, this position finds statutory recognition under the Transplantation of Human Organs Act, 1994[8], primarily within the context of organ donation, though its implications extend far beyond it.

If cognition has irreversibly ended, what remains is not life in its human sense, but mere biological persistence. Yet the law resists drawing this line with finality. It fears that to define death too readily is to risk authorising its premature conclusion thus privileging caution over clarity.

III. The Harish Rana Delay: Justice Measured in Years

The case of Harish Rana, frequently invoked in debates on euthanasia, lays bare the law's slow and uncertain movement in this domain. His condition, prolonged, irreversible, and medically settled, remained suspended within procedural and ethical deliberation for nearly thirteen years. The delay, though often attributed to administrative inertia, reveals something deeper: an institutional reluctance to confront finality where consequence admits no correction.

Courts demanded repeated medical verification; families bore the weight of social suspicion and moral scrutiny; authorities hesitated, wary that any precedent might be misapplied beyond its intended limits. As one scholar observed, delay in such cases is not merely procedural—it

[8] Transplantation of Human Organs and Tissues Act, 1994, No. 42, Acts of Parliament, 1994 (India).

is moral hesitation, structured and legitimised through process. In attempting to prevent a wrongful death, the system risks perpetuating a life stripped of conscious experience. Protection, at this threshold, begins to resemble paralysis.

Judges, unlike legislators, do not operate in abstraction. They encounter singular lives, irreducible suffering, and decisions that cannot be undone. In Common Cause v. Union of India (2018)[9], the Supreme Court acknowledged this burden, though implicitly. The judgment speaks not with assertive clarity, but with calibrated restraint recognising the right to die with dignity while enclosing it within safeguards so exacting that its invocation remains exceptional.

Judicial reflections echo this unease. The fear is not of permitting death, but of permitting it wrongly. It is this apprehension that shapes the law's cautious architecture across jurisdictions. Whether in India, the United Kingdom, or the Netherlands, certain principles converge: preservation of life where recovery is possible, primacy of medical opinion, safeguards against coercion, and the recognition that dignity must not be subordinated to mere prolongation.

Medicine, too, operates within this convergence. The critical challenge lies not in intervention, but in its cessation. At this juncture, law and medicine intersect not to abandon life, but to acknowledge the limits beyond which intervention ceases to heal and begins to harm.

The central ethical tension in euthanasia arises from the collision of two competing truths. First, hope compels continuation, for recovery, however improbable, remains within the realm of possibility. Second, dignity demands restraint, for existence devoid of awareness challenges the very meaning of life itself. The law, positioned uneasily between these claims, does not resolve the conflict; it manages it. It constructs a framework where decisions are undertaken with caution, marked by hesitation, and bound by accountability, an acknowledgment that while certainty is unattainable, responsibility cannot be avoided.

IV. Conclusion

At the edge of life, the law does not assert itself with certainty. It does not proclaim resolution, nor does it claim dominion over outcomes it cannot fully comprehend. Instead, it retreats into procedure, into safeguards, into layers of approval that appear, at first glance, excessive. Yet this retreat is not weakness; it is recognition. It reflects an awareness that where life, medicine,

[9] *Common Cause*, (2018) 5 SCC 1.

and morality converge, certainty dissolves into responsibility.

In this space, justice is redefined. It is not the authority to determine death, but the discipline to resist the unnecessary prolongation of suffering. Life, when it approaches its natural boundary, does not demand compulsion; it calls for acceptance. The role of law, then, is not to hasten this end, nor to obstruct it blindly, but to ensure that its arrival is neither premature nor unduly resisted. In that balance lies its humanity.