
RIGHT TO DIE WITH DIGNITY: SHOULD PASSIVE EUTHANASIA BE MADE ACCESSIBLE TO MARGINALIZED COMMUNITIES?

Asra Siddiqui, B.A.LL.B., City Academy Law College
(Affiliated to University of Lucknow, Lucknow)

ABSTRACT

While affluent and elite demographics, possess enough resources and awareness to navigate accessibility problems and claim their rights, the underserved and Marginalized groups faces various barriers that restricts their access and they are often deprived of their legal rights, this paper investigates these disparities and aims to contribute to social justice and equity in society. It also highlight the perpetual inequity in realization of legal rights and need for feasible pathways with a view to making society more egalitarian. This paper helps to shape the understanding regarding the extent to which these hurdles restrict the accessibility and what may be it's possible and effective solutions. Although multiple hurdles exists, this piece of writing along with key ethical debates, exposes four primary barriers which is restricting the accessibility of passive euthanasia. By adopting doctrinal research methodology and relying on landmark judgments, official government reports and statistical data, existing secondary literature including peer-reviewed research papers, this work is completed. In the end the paper concludes by suggesting active and needed reforms and suggestions to ensure proper implementation and reduce problems of these vulnerable groups.

Keywords: Passive Euthanasia, Marginalized communities, Article 21, Living will, End-of-life care, Lack of accessibility.

Statement of Problem

Article 21 has been judicially expanded to encompass the Right to die with dignity as the Supreme Court accorded legal sanction to passive euthanasia, providing a structure guidelines for its implementation. However empirical realization remains deeply stratified across different sections of the society. Consequently, the Socio-economic exclusion creates a massive gap in it's implementation and addressing this problem is critical to bring systemic reform and integrate them into legal and healthcare mainstream. Highlighting this problem is necessary to study various dimensions of end-of-life right and ensure equitable access across sociodemographic segments.

Research Methodology

This study adopts a doctrinal methodology and analytical method of research. This paper is based on Constitution provisions, judicial pronouncements, government reports like report of ministry of health and family welfare. This study also adopts a quantitative research methodology utilizing secondary data collected from authentic available resources .Furthermore, it is based on secondary sources such as peer-reviewed journal articles and legal resources that analyses judicial developments and hearings. By analysing real gap between legal framework and it's actual implementation this paper evaluates the ground reality and identifies critical areas for systematic reforms.

Introduction

The Constitutional grant of 'Right to Life' under Article 21 , remain incomplete if the law forces a terminally ill patient to mere biologically survival when dignity in life has become impossible and medical consensus offers no hope of recovery. In such case person shall have the right to choose their death. When the condition of a person is such that it completely erodes human dignity, the legal system of any country must ensure right to die with peace and dignity along with right to live with dignity.

The true essence of de jure law lies in its accessibility to the underprivileged, otherwise it becomes merely an on-paper existing law. Right to die with dignity is a necessary one and the legal framework should be such that it is accessible to all in need. This paper highlights the problem of inaccessibility of this right to the people at margin of the society. Although the

Supreme Court of India officially legalised Passive Euthanasia in 2018, it's first practical implementation was witnessed eight year later in 2026. This gap somehow shows the profound lack of accessibility and systematic failure especially to most vulnerable, making this framework a systematic myth.

Marginalized communities are groups facing structural, economical and caste based discrimination and generally left behind and outside the mainstream of the society. They often make up a significant vast portion of India and it is a necessity to talk about them and their participation and accessibility for a prosperous and ethical society.

By highlighting actual and ground level barrier this paper moves beyond the legal text and adds new knowledge and shifts focus to the problems they face. By addressing unique existing barriers such as these vulnerable groups have no proper access to quality healthcare, their lives revolves around specific limited resources and areas. They are highly influenced by societal values cultural norms and face various hurdles in everyday life and so on . Furthermore it discuss major established ethical debates, this piece of writing exposes the gap between on paper laws and real world practice.

Meaning and Concept of Euthanasia and Passive Euthanasia

Etymologically the term 'Euthanasia' is derived from the ancient Greek word that includes 'eu' means 'good' or 'well' and word 'thanantos' means 'death' , Thus, the entire meaning of this word is a 'good death'. Simply Euthanasia can be understood as Mercy killing, means an act of intentionally ending of painful life of a person suffering from painful and incurable disease such as being in a permanent vegetative state. Euthanasia covers various categories that are- Active and Passive euthanasia; Voluntary and Involuntary euthanasia and Physician assisted Euthanasia. The practice of euthanasia is debatable across legal, ethical, religious, human rights, health and cultural aspects as it arises the conflict between the state's interest in preserving the sanctity of life and an individual's constitutional right of dignified death under article 21. However hon'ble Supreme Court in India has ruled that passive euthanasia is legally permissible, allowing terminally ill individual to right to die with dignity.¹ Euthanasia is Medically and legally bifurcated into:

¹ Suresh Bada Math and Santosh K Chaturvedi, Euthanasia: Right to life vs Right to die, 136 INDIAN J. MED. RES. 899,899 (2012)

a) Active Euthanasia.

b) Passive Euthanasia.

a) Active Euthanasia – Active Euthanasia involves active and deliberate steps to end a patient's life. This act include administration of lethal substances such as Sodium pentothal or injunctions which actively cause death of patient.

As the Supreme Court in case of Harish Rana vs UOI (2026), reaffirmed that “Active Euthanasia” refers to a positive contribution to the acceleration of death. Active euthanasia also includes physician assisted suicide where the injection or drugs are supplied by the physician but the act of administration is done by the patient himself.² Active Euthanasia is illegal in India as the highest court expressed its view primarily due to the high risk of misuse, corruption, and ethical degradation in society, Active Euthanasia cannot be allowed in India.

b) Passive Euthanasia – Unlike active euthanasia, Passive Euthanasia does not accelerate the patient's death rather it allow patient in permanent vegetative state to die naturally by simply stopping life- prolonging treatment.

Passive Euthanasia is legally recognised practice wilfully allowing the omission of medical treatments to a terminally ill permanently vegetative patient to die and face a natural death. In this act, the life supporting measures proposed to extend the life artificially are withdrawn or withheld. According to the aforesaid Harish Rana judgment, passive euthanasia may also include actions such as “disconnecting life support machines, removing feeding tubes, or withholding life-saving operations and life-extending drugs.”³ The Passive Euthanasia allows a patient, or their guardian if the patient is unconscious, to authorise medical practitioners to withdraw medical treatment and let the patient die naturally when there is no prospect for any recovery and restore functional health.

The Legal Status of Passive Euthanasia in India

In Aruna Ramchandra Shanbaug case, marking a legal paradigm shift on March 07, 2011 , the Supreme Court of India for the first time judicially recognized Right to die with dignity within the constitutional ambit of Article 21 of Indian constitution and legalised Passive Euthanasia

² Harish Rana v. Union of India, (2026) SCC OnLine SC 358

³ Harish Rana v. Union of India, (2026) SCC OnLine SC 358.

in India.⁴ In this case, (According to Indian Kanoon (Source 7), Ms Shanbaug ,a staff nurse was left with severe brain damage and paralysed after attacked by ward attendant in the mumbai hospital and was Sodomised and a chain was twisted around her neck due to which oxygen supply to her brain stopped and her brain got damaged. The case was filed to provide passive euthanasia and let her life-prolonging treatment be ended after decades in a permanent vegetative state. However, Pinki Virani who claims to be the next friend of Aruna and file petition on her behalf was declined by court to be recognised as Aruna's next friend and the KEM hospital staff which has been looking after her for years and considered as next friend want to keep Aruna alive and looking after her until her natural death. Aruna never received passive euthanasia and in may 2015 she passed away due to pneumonia. This landmark judgment provided India it's first ever legal framework and legalised passive euthanasia for the future. The court also laid down following procedure to be followed when the patient is incompetent to give consent :

- 1) For granting or denying the approval of the matter , the High Court should constitute a bench of at least two judges.
- 2) Before deciding matter, the bench should seek the opinion of committee containing three reputed doctors. Such doctors shall be nominated by bench.
- 3) The committee of doctors should carefully examine the patient and shall submit it's report to the High court.
- 4) The High court bench shall also issue notice to the state and close relatives of patient and also supply copy of report of committee of doctors.
- 5) After following said procedure, the court should give its final verdict.⁵

While this case legalized passive euthanasia, the court also elucidated the conceptual framework of living will but remain evidently silent regarding the legality of advance medical directives i.e. living wills.

Later, In an another landmark case Common Cause vs Union of India (2018)⁶ the Supreme

⁴ Aruna Ramchandra Shanbaug v. Union of India, (2011) 4 SCC 454.

⁵ Aruna Ramchandra Shanbaug v. Union of India, (2011) 4 SCC 454.

⁶ Common Cause (A Regd. Society) v. Union Of India, (2018) 5 SCC 1.

Court decided the core issue of Advance medical directives (living will) and also permanently incorporated “right to die with Common dignity” in constitution of India. The Apex court explicitly gave legal right to individuals to execute advance medical directives, this allowed individual to declare to refuse being kept in a state of prolonged, vegetative suffering in advance that if in future, he or she becomes permanently unconscious or in permanent vegetative state and not able to express their desires because they are unconscious, in a coma, or in a permanent vegetative state. The court also to ensure safe implementation laid down legal framework including formation of medical boards, legal authenticity of living will, and Safeguard against the coerced cessation of life-sustaining treatment.

As a modification of 2018 guidelines, in January 2023 the Supreme Court simplified the structural complications to avail passive euthanasia. The new guidelines reduced the experience criteria of doctors to 5 years which was previously 20 years. The total number of members on the medical boards has been reduced to 3 experts. Further, the chief district medical officer (CDMO) may now nominate a qualified representative to a medical board and his personal attendance is no longer required. The boards are required to give its opinion preferably within 48 hrs. Additionally, the court has simplified the verification process, now the verification of advance medical directives by judicial magistrate first class is no longer required, and it may be legally verified before Notary of Gazetted officer.⁷

The execution of passive euthanasia was addressed for the first time in practice through the landmark judgment of Harish Rana v. Union of India (2026). This case marks first real-world, court-approved execution of passive euthanasia. The patient name Harish Rana met with an accident in consequences of which he had suffered for many years, was in a permanent vegetative state and there was no hope of his recovery. He was since about 13 years, received food and water through feeding tube. Medical boards declared that “he would never be able to recover and live a normal life”. Considering the situations, The hon’ble Supreme Court allowed the withdrawal of life-sustaining treatment. This case became significant precedent in which passive euthanasia was actually applied in real-world. The Supreme Court also urged the Union government to make comprehensive legislation on the subject.⁸

⁷ Advay Vora, *Supreme Court Review 2023: Right to Life*, SUPREME COURT OBSERVER, (Dec. 29, 2023), <https://www.scobserver.in/journal/supreme-court-review-2023-right-to-life/>

⁸ Harish Rana v. Union of India, (2026) SCC OnLine SC 358

Socio-Structural Barriers to Accessing Passive Euthanasia

The Supreme Court has legitimated the Passive Euthanasia under Article 21 to safeguard end-of-life dignity but for the disadvantaged or marginalized groups it is not only a healthcare choice but is deeply entangled within multifaceted inequities also. On evaluation of the right to die with dignity through the lens of marginalized communities, the empirical reality of its availability is completely different from the legislative framework. Various hurdles confronting by them can be understood in following interpretive framework.

Lack of access to quality healthcare

The marginalized communities face problems due to remote locations, unbearable costs, inadequate staffing and others. A significant number of marginalized groups reside in rural and undeveloped regions and frequently experience acute shortage of trained medical personnel, palliative care and other multidisciplinary resources in hospitals, which makes procedural safeguards mandated under Supreme Court guidelines practically inaccessible.

This resource gap is empirically confirmed by a report of survey conducted in 2022 using IAP (Indian Association of Palliative care) standards audit tool, only 5.8 percent of respondents have proper uninterrupted access to oral-morphine and provide immediate-release oral morphine which helps in implementation of Passive Euthanasia to stop severe pain and enable peaceful death. Further the report found only 5 percent responded centres have trained personnel and staff.⁹ This report reflects national data, including dedicated palliative-care centres, so it is concerning that the marginalized population who heavily depend on underfunded public or rural health centres, face such resources gap which make accessibility practically unattainable. If local hospitals are inadequately equipped to constitute the required medical boards, then families are driven to travel to distant district/ tertiary hospitals; then the additional load of travelling costs, significant travelling time, and daily wages of working family members who rely on daily earnings are affected, and these factors further become reasons for inaccessibility.

Marginalized communities specifically tribal communities are often facing poor healthcare accessibility mainly due to geographical barriers. Since tribal communities inhabit remote

⁹ Arunangshu Ghoshal et al. , *Situational analysis of the quality of palliative care services across India: a cross sectional survey*, 16, ECANCERMEDICALSCIENCE 1,4 (2022).

distanced from mainstreams urban centres, geographical reasons are thus a barrier to healthcare access, Tribal people mainly depend on healthcare system where shortage of medical staff, medical equipment, supply of necessary medicines, exists. In a study, it was found that there is 20 percent unavailability of medical officers in primary health centres (PHC) and 8 percent critical shortage of trained health personnel. This study shows if a community lacks basic primary care, the legal right to die with dignity becomes logistically impossible because if a hospital lacks basic medical infrastructure, then advanced medical infrastructure, specialized equipment and formation of medical review boards becomes practically impossible to fulfill the requirements.¹⁰

Legal illiteracy

Legal literacy is a vital instrument one can use to achieve social justice and to access and claim their rights. The existence of a Legal right and its availability is two different things and the latter can be effectively achieved through legal literacy and awareness. A large population in India, especially residing in rural areas and marginalised communities is still unaware of their available rights and legal remedies.

Marginalized communities faces barriers to justice due to low awareness of free legal aid available to them, Lack of knowledge about basic procedures in law and High reliance on informal or often exploitative channels alongside structural and socio-economic hurdles. As per section 12 of legal services authorities act 1987 Schedule Caste, Schedule Tribes, women, children, victim of caste atrocities and ethnic violence etc. are eligible groups for free legal aid. As stated in NALSA Annual report (2023) report shows awareness of legal rights among these eligible population is only limited to 20 – 30%.¹¹ United nations development programme (UNDP) India conducted the “People-Centred Justice Needs Assessment” survey from 2,500 people from marginalized communities across six states and revealed that 80% had never heard legal aid and never used it. This underscores pressing need for targeted awareness programmes to vulnerable demographics about their existing legal rights and entitlements.¹²

¹⁰ Dinesh Kumar et al. , *Identifying potential community barriers for accessing health care services context to health for all in rural-tribal geographical setting in India: A systematic review* , J. CMTY. HEALTH MGMT. 169, 174 (2022).

¹¹ Udit Kumar Verma, *Legal Aid in India: Is it Failing for the People Who Need it Most*, JUS CORPUS LAW JOURNAL, (Aug.23, 2025), <https://www.juscorpus.com/legal-aid-in-india-is-it-failing-for-the-people-whoneed-it-most/>

¹² Isabelle Tschan and Sneha Pathak, *Enhancing Access to Justice in India: Reaching the Last Mile*, UNDP

As per 2011 census, In India almost 68% population lives in rural India. Marginalized groups specially Tribal communities maintains strong cultural affinity, historical attachment with their agrarian land and forest and majority of them concentrated in these areas. A 2023 survey conducted in rural Jharkhand (predominantly rural and tribal demographics) is an indicative evidence which shows lack of legal awareness (40.1%) as a barrier in accessing justice.¹³

Social Stigma

Legally permitted withdrawal of life sustaining treatment is not equal to social approval. For marginalized communities, social stigma is a kind of social disapproval and fear of social exclusion that affects their very decisions of life. Further it isn't just societal label but includes personal beliefs and attitudes too.

Religious and traditional beliefs constitute an independent, deeply rooted and primary decision grounds which affects their decisions regardless of other factors. Indian society holds the view that life is sacred and majority of religions considers interfere with the Almighty's regarding time of death to be a sin. According to Navandar and Choudhary (2026) ,certain religious traditions permits a conscious acceptance of death under specific circumstances (e.g., Paryopavesa, Sallekhana).¹⁴ However, for these communities such nuanced interpretation may be less possible and society may label the consenting passive euthanasia as a sin. This stigma often creates a barrier in accessing legally permitted passive euthanasia.

The Supreme Court in Common Cause judgement makes a specific observation that this decision is often viewed as an abandonment or failure of moral obligation towards members. The family though willing to discontinue the treatment may unable to avail passive euthanasia, due to social pressure that even if they have capacity to continue treatment they may be perceived as having "chosen not to" do so.¹⁵ Consequently , one could infer that closely-knit, smaller marginalized communities may be more visible and judged by society and surrounding people and they rely heavily on mutual cooperation, community network for their

INDIA, (May 25, 2026), <https://www.undp.org/india/blog/enhancing-access-justice-india-reaching-last-mile>

¹³ Sunil Chauhan, *Legal Needs in Rural India: Challenges & Response of Legal Aid Authorities*, CENTER ON THE LEGAL PROFESSION HARVARD LAW SCHOOL, (last visited Oct. 03, 2026), <https://clp.law.harvard.edu/wp-content/uploads/2023/06/Legal-needs-in-Rural-India-conference-paper-SunilChauhan.pdf>.

¹⁴ Priyanka Navandar and Nareshkumar Choudhary, *Euthanasia in India: A Legal, Socio-Cultural, and Psychological Analysis of the Right to Die with Dignity*, 14 INT'L J. RES. APPLIED SCI. & ENG'G TECH. 5520, 5523-5524 (2026).

¹⁵ Common Cause v. Union of India (2018) 5 SCC 1.

interdependent survival. Hence, these societal labelling and stigma affect them even more acutely.

Bureaucratic hurdles

Beside above discussed impeding factors, the bureaucratic hurdles significantly compound the accessibility impossible. Despite simplified guidelines of the Supreme Court, the practical accessibility is still disproportionately restricted to select demographic segments. The Supreme Court guidelines 2023 clarified that for approval of withdrawal of treatment, the formation of two separate medical boards consists of specialised doctors.

The Ministry of Health and family welfare (MoHFW) report, health dynamics of India, 2022¹⁶ reveals the major gap between real implementation and ground reality of rural healthcare and shows the deficiency of needed specialised doctors in rural CHCs. There is almost 79.9 percent shortfall in community healthcare centres (CHCs).¹⁶ The under reserved population often rely heavily on under-resourced rural public health infrastructure and financial condition restricts their ability to absorb the steep transportation cost associated with availing urban healthcare. Withdrawal of life supporting treatment is not possible without approval of these boards vulnerable families are often left with no choice and exorbitant ICU costs may compel them to opt for LAMA as continuing treatment may drive them to generational medical debts.

34 out of 36 states and UTs fallen sort of executing the statutory protocols required for implementation of advance medical directives (AMD). 5.5 percent States attains successfully operational status strangled by tech dominated process and steep financial barriers.¹⁷ This systematic breakdown disproportionately harms marginalized communities by stripping away essential physical infrastructure and locks out them entirely turning a Constitutional right into an absolute myth.

Ethical Debates on Passive Euthanasia and Marginalized Communities

1. Autonomy Vs Societal Values – The raison d'être behind the Supreme Court legalising passive euthanasia is to secure the human dignity and autonomy at the end stage of life

¹⁶ Ministry of Health and Family Welfare, *Health Ministry Releases “ Health Dynamics of India (Infrastructure and Human Resources) 2022-23 ”*, PRESS INFORMATION BUREAU (Sep. 09, 2024, 12:38 PM), <https://www.pib.gov.in/PressReleasePage.aspx?PRID=2053070®=48&lang=2>.

¹⁷ Vipin Kumar, *Living Wills in India: A Complete Guide to End-of-Life Autonomy and Legal Framework*, SSRN, (Sep. 15, 2026), <https://share.google/omdJFyasHmZVhQaud>

of a person. Continuing life with Dignity becomes unattainable when life is prolonged by artificial means. In Common Cause judgement (2018) by officially legalising Right to die with dignity, a person's moral and legal right of self determination and autonomy under Article 21 was upheld.

However, this Autonomy-centred approach clashes heavily with established societal and communal norms especially within marginalized communities. Their norms are knitted by deep socio-structural and historical dynamics. End of life at this stage is not only based on individual autonomy but viewed through cultural, religious and societal lens also. Their thoughts clashes fearing of vulnerability, being neglect and survival.

Necessity of protecting dignity vs Risk of misuse

The primary endeavour of passive euthanasia is preservation of bodily integrity and dignity in such end-of-life decisions. The prolonged suffering must be mitigated and person should not be forced to continue life of vegetative existence merely because legal ambiguities surrounding the refusal of treatment, that compelled the Apex court to grant it legal recognition.

Controversially, A profound legal conflict persists, especially in case of Marginalized groups, the severe risk of its misuse exists. The families with poor financial condition might withdraw the treatment because of out of pocket expenditure and being incapable to continue the life prolonging treatment, this transforms 'Right to die' into 'duty to die' . Furthermore family members or heir might greedily choose passive euthanasia to secure property interest.

Conclusion

Across India's densely populated and immense geographical spread, the implementation of any statutory right or legal framework is a monumental administrative challenge, but to die with dignity is a fundamental right and socio-structural barriers must not overshadow the duty of state to fulfil the mandate of providing such dignity and autonomy at the end of life. The limited access of any right to only socio-economic privilege classes is directly against Article 14 of the Indian constitution.

This study brings light to the four main barriers, which restraints and widens the gap between this framework and it's practice. The marginalized communities face a deficit in legal literacy and remain bound by community norms and stigma which often restricts it's accessibility due

to misconceptions and myths about passive euthanasia. Even if individual somehow bypass these barrier, they are ultimately forced to capitulate to the persistent systemic barriers. Consequently, it is unrealistic to expect these already vulnerable groups to overcome such barriers entirely on their own. The equal and active support of state and providing fair opportunities can play a vital role in increasing accessibility.

Ultimately highlighting these hurdles is essential and this paper also provide actionable suggestions to overcome the barriers faced by these vulnerable groups. However while this study addresses the main persistent barrier in this piece of work, it was not feasible to exhaustively analyse every existing barrier but it offers useful and enough to shift the policy attention towards actual and meaningful implementation of Passive Euthanasia.

Suggestions

- 1. Grassroots Awareness Campaigns in Vernacular language:** Insufficient awareness often leads to profound misconceptions and stigma. To bridge the gap of low legal literacy and information asymmetry, The government should deploy target-driven awareness campaign in local languages to educate underserved groups for simplification of these convoluted legal framework and it's complex mechanism.

- 2. Codified legislation:**

The lack of proper implementation of framework suggests that there is a need of proper legislation on Passive euthanasia. By codification it's accessibility can be expanded beyond urban cities and affluent classes. Along with other bureaucratic barriers, the present government data (earlier discussed 2022-23 health ministry report) is an evidence that proper availability of staff and specialists is somewhere inadequate specially in Regional hospitals, so proper law including binding regulations to mandate the minimum staff should be framed and government should notify pre-approved required panels to meet these requirements. Provisions such as time bound decision, facility of digital registry of living will and other required statutory measures should also be added.

- 3. Rural Palliative care reform:**

Pan-India data highlights the deficient palliative care availability, so from the lens of

marginalized communities this situation is exceptionally more critical. This paper suggests that for proper accessibility of healthcare targeted-resources allocation and community led-care should be institutionalised. The Government must allocate budget for supply of required resource of palliative care medicines directly to primary healthcare centres and it must also ensure that it actually reach to the ground level.