

From Spiritual Renunciation to Constitutional Autonomy: The Evolution of Voluntary Death and Euthanasia in India

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Abstract

Advances in medical technology have transformed the experience of dying by enabling respiration, circulation, nutrition and other physiological functions to be sustained for prolonged periods even where the underlying disease is irreversible and meaningful recovery is medically improbable. This development has intensified the legal and ethical debate concerning euthanasia, withdrawal of life-sustaining treatment and the constitutional meaning of a dignified death in India. The question is no longer confined to whether life should be preserved, but extends to whether a person may, under legally regulated circumstances, refuse or discontinue medical intervention and permit the natural process of dying to occur. The issue has become particularly significant in cases involving terminal illness, permanent vegetative states and other conditions in which medical intervention may sustain biological functioning without restoring consciousness or meaningful recovery. The normative question of voluntary death, however, is not wholly unfamiliar to Indian jurisprudential thought. Jain traditions recognise *sallekhana*, while Hindu philosophical and Dharmashastric traditions contain references to *prayopavesa* and related forms of voluntary fasting unto death under particular conditions. These practices cannot be equated with modern euthanasia because their normative foundations lay in dharma, karma, ahimsa, renunciation, spiritual purification and detachment rather than in contemporary ideas of medical autonomy and patient-centred decision-making. Nevertheless, they demonstrate that Indian intellectual traditions have long reflected upon suffering, mortality, agency and the manner in which death may be consciously approached. This paper examines the movement from these ancient normative frameworks to contemporary constitutional jurisprudence. It traces the judicial development from *P. Rathinam v Union of India* and *Gian Kaur v State of Punjab* through *Aruna Ramachandra Shanbaug v Union of India* and *Common Cause v Union of India* to the Supreme Court's 2026 decision in *Harish Rana v Union of India*. The paper argues that Indian euthanasia jurisprudence represents normative continuity without doctrinal equivalence. Ancient approaches located voluntary death within spiritual discipline and renunciation, whereas contemporary constitutional law relocates the question within autonomy, dignity, privacy, bodily integrity, informed consent and protection of vulnerable persons. The recent Harish Rana decision demonstrates that this jurisprudence continues to evolve in response to developments in intensive care, clinically assisted nutrition and hydration, and the practical difficulties of end-of-life decision-making.

Keywords: Euthanasia; right to die with dignity; Article 21; *sallekhana*; *prayopavesa*; passive euthanasia; advance medical directive; end-of-life care.

1. Introduction

Modern medicine has altered the temporal and experiential character of dying. Intensive care, mechanical ventilation, artificial nutrition and hydration, renal replacement therapy and other technologies can sustain physiological functions long after the prospect of recovery has become extremely remote. The resulting ability to postpone biological death creates a legal problem that earlier generations did not encounter in the same form: when treatment no longer cures the underlying condition and instead prolongs the dying process, is continued intervention always legally and ethically required?

Indian law approaches this question through Article 21 of the Constitution. The Supreme Court has progressively interpreted the right to life as encompassing dignity, privacy, bodily integrity and decisional autonomy. End-of-life decisions therefore cannot be reduced to a simple opposition between preservation of life and termination of life. The more precise inquiry concerns whether a competent person may refuse unwanted treatment, whether previously expressed wishes may guide decisions after incapacity, and under what safeguards life-sustaining treatment may be withheld or withdrawn when its continuation no longer serves a legitimate therapeutic purpose.

At the same time, the Indian debate has an important historical dimension. Voluntary approaches to death were discussed in ancient religious and philosophical traditions. Jainism developed *sallekhana* as a disciplined practice of gradual bodily withdrawal, while Hindu traditions contain references to *prayopavesa* and other forms of fasting unto death in defined circumstances. Contemporary scholarship cautions against treating these practices as ancient equivalents of euthanasia; their purposes and normative structures were religious and spiritual rather than medical or constitutional.¹

The central claim of this paper is therefore that the history of voluntary death in India is best understood through the proposition of normative continuity without doctrinal equivalence. The continuity lies in the longstanding Indian engagement with suffering, detachment, agency and mortality. The doctrinal transformation lies in the source of legal legitimacy: ancient practices derived their legitimacy from religious and philosophical norms, whereas contemporary end-of-life decisions derive legitimacy from constitutional rights, medical ethics and judicially developed safeguards.

2. Conceptualising Euthanasia, Treatment Withdrawal and Dignified Dying

Euthanasia, passive euthanasia, physician-assisted suicide, withholding treatment and withdrawal of treatment are frequently used interchangeably in public discussion, although they involve materially different legal and ethical questions. Active euthanasia generally denotes an affirmative act intended to cause death. Physician-assisted dying ordinarily involves the provision of means by which a patient performs the final life-ending act. By contrast,

¹ Sethi, M. (2019). Ritual death in a secular state: The Jain practice of *Sallekhana*. *South Asian History and Culture*, 10(2), 136–151. <https://doi.org/10.1080/19472498.2019.1609261>. See also Braun, W. (2008). *Sallekhana: The ethicality and legality of religious suicide by starvation in the Jain religious community*. *Medicine and Law*, 27(4), 913–924.

withholding or withdrawing life-sustaining treatment permits the underlying disease or condition to take its course.

The distinction is crucial in Indian law. The Supreme Court has not recognised an unrestricted constitutional right to active euthanasia. Instead, the jurisprudence has developed around refusal, withholding and withdrawal of life-sustaining treatment in circumstances satisfying constitutional and procedural requirements. The 2024 Indian Society of Critical Care Medicine and Indian Association of Palliative Care consensus position emphasises that an adult with decision-making capacity may refuse life support and that withdrawal of life-sustaining treatment is legally distinct from intentional killing.²

Recent bioethical scholarship similarly stresses that the moral relationship between euthanasia and treatment refusal cannot be resolved merely by asking whether both decisions may result in death. Autonomy and bodily integrity can generate distinct rights, and the legal character of a medical decision depends upon intention, causation, consent and the nature of the intervention.³

Consequently, the expression 'right to die with dignity' in Indian constitutional law should not be interpreted as a general licence to cause death. It is more accurately understood as a limited constitutional protection against unwanted or futile medical intervention and as recognition that the final stage of life must be approached consistently with human dignity.

3. Ancient Indian Conceptions of Voluntary Death

Ancient Indian jurisprudence cannot be analysed exclusively through modern categories of autonomy or individual rights. Concepts such as dharma, karma, moksha, ahimsa, tyaga and vairagya supplied the normative vocabulary through which life and death were understood. Death was commonly situated within a larger philosophical account of existence, rebirth and liberation rather than treated solely as biological cessation.

Within Hindu traditions, the movement from worldly engagement toward renunciation supplied a context in which the final stage of life could be understood as a period of detachment and spiritual preparation. The classical ashrama framework is historically complex, but scholarship has demonstrated the importance of renunciation as a distinct institution in Indian religious thought.⁴

Prayopavesa is associated in traditional sources with fasting unto death under specified circumstances. It should not be represented as an unrestricted religious permission to commit suicide. Its normative legitimacy depended upon context, intention, discipline and conformity with the individual's religious and social duties. The conceptual significance of *prayopavesa*

2 Mani, R. K., Bhatnagar, S., Butola, S., Gursahani, R., Mehta, D., Simha, S., et al. (2024). Indian Society of Critical Care Medicine and Indian Association of Palliative Care Expert Consensus and Position Statements for End-of-life and Palliative Care in the Intensive Care Unit. *Indian Journal of Critical Care Medicine*, 28(3), 200–250. <https://doi.org/10.5005/jp-journals-10071-24661>.

3 Rivera-López, E. (2024). Euthanasia, consensual homicide, and refusal of treatment. *Bioethics*, 38, 292–299. <https://doi.org/10.1111/bioe.13261>.

4 Olivelle, P. (1993). *The Āśrama System: The History and Hermeneutics of a Religious Institution*. Oxford University Press.

for the present inquiry lies in the fact that Indian traditions could regard conscious acceptance of death as morally intelligible without reducing the act to a modern claim of personal autonomy.

Jainism provides an even more developed example through *sallekhana*. The practice is associated with the gradual reduction of bodily attachments, equanimity and spiritual purification. Contemporary scholarship emphasises that *sallekhana* must be distinguished from ordinary suicide and from modern euthanasia.⁵ The Rajasthan litigation concerning the practice demonstrated the difficulty of fitting a religious discipline into modern legal categories of suicide, religious freedom and the right to life.⁶

The distinction is therefore essential. *Sallekhana* does not ordinarily involve a physician intentionally causing death to relieve medical suffering. Its religious rationale is connected with detachment and liberation. Modern euthanasia, by contrast, is embedded in clinical decision-making, patient consent, professional responsibility and legal regulation.

4. From Spiritual Renunciation to Constitutional Autonomy

The transition from ancient approaches to modern euthanasia is not a simple movement from religion to law. Rather, it represents a transformation in the normative vocabulary through which voluntary dying is justified. Ancient traditions evaluated death through *dharma*, *karma*, *ahimsa*, spiritual purification and renunciation. Contemporary constitutional jurisprudence evaluates end-of-life decisions through autonomy, dignity, privacy, bodily integrity, informed consent, best interests and protection of vulnerable persons.

Recent empirical and clinical literature reinforces the importance of this transformation. A 2025 scoping review of end-of-life care in India found that services remain fragmented, with significant regional inequalities, shortages of trained personnel, inadequate infrastructure and substantial financial and psychosocial burdens on patients and caregivers.⁷ A 2024 national analysis of supportive and palliative care needs among older adults likewise demonstrates the scale of the need for end-of-life services.⁸

This context matters to the autonomy argument. A formal right to refuse treatment is meaningful only where the patient has access to appropriate information, symptom control, palliative care and a decision-making environment free from coercion. The ethical legitimacy of end-of-life autonomy therefore depends not only upon constitutional recognition but also upon the availability of alternatives to aggressive medical treatment.

5 Jaini, P. S. (1979). *The Jaina Path of Purification*. University of California Press; Dundas, P. (2002). *The Jains* (2nd ed.). Routledge.

6 Sethi, M. (2019). Ritual death in a secular state: The Jain practice of *Sallekhana*. *South Asian History and Culture*, 10(2), 136–151. <https://doi.org/10.1080/19472498.2019.1609261>.

7 Varkey, B. P. A., Ghoshal, A., Salins, N., & Mayland, C. R. (2025). Mapping end-of-life care in India: A scoping review to identify gaps in policy, practice, and psychosocial support. *Palliative Care*, 24, 189. <https://doi.org/10.1186/s12904-025-01825-z>.

8 Immanuel, T., Salins, N., Thomas, M. B., Sundararaj, J. J., et al. (2024). Supportive and palliative care needs among older adults in India: An estimation using a nationally representative survey. *BMC Palliative Care*, 23, 274. <https://doi.org/10.1186/s12904-024-01604-2>.

Indian scholarship increasingly treats advance care planning as an essential bridge between constitutional doctrine and clinical practice. The legal recognition of advance medical directives in 2018, followed by procedural simplification in 2023, has created a framework through which individuals may communicate their wishes before losing decision-making capacity.⁹

5. Constitutional Foundations: Article 21, Dignity and Autonomy

Article 21 provides that no person shall be deprived of life or personal liberty except according to procedure established by law. The Supreme Court's interpretation of the provision has moved substantially beyond mere physical existence. In *Francis Coralie Mullin*, the Court connected life with human dignity; subsequent jurisprudence expanded Article 21 to encompass privacy, decisional autonomy and bodily integrity.

In Justice *K.S. Puttaswamy (Retd.) v Union of India*, the nine-judge Constitution Bench recognised privacy as a constitutionally protected right and linked privacy with autonomy, dignity and the ability to make intimate personal decisions.¹⁰ Medical treatment lies at the heart of this protected sphere because decisions concerning the body, pain, invasive treatment and the continuation of life-support are deeply personal.

The principle of informed consent provides the immediate medical expression of autonomy. A competent adult is ordinarily entitled to accept or refuse medical intervention even where refusal may result in death. The ISCCM-IAPC 2024 consensus statement expressly recognises this proposition and places end-of-life decision-making within autonomy, beneficence, non-maleficence and justice.¹¹

Autonomy, however, is not absolute. Where a person lacks decision-making capacity, the legal system must determine whose judgment should guide treatment. Advance directives, substituted judgment and best-interests analysis are mechanisms for ensuring that incapacity does not automatically erase the individual's constitutional identity.

P. Rathinam and Gian Kaur: From a Right to Die to a Right to Die with Dignity

The modern constitutional controversy began prominently with *P. Rathinam v Union of India*. The Supreme Court's 1994 decision treated the right to life under Article 21 as including a right to die and invalidated the criminalisation of attempted suicide under Section 309 of the Indian Penal Code. The decision represented an expansive interpretation of personal liberty but did not survive constitutional reconsideration.

In *Gian Kaur v State of Punjab*, the Constitution Bench rejected the proposition that Article 21 contains a general fundamental right to die. At the same time, the Court recognised that the

9 Mani, R. K., Simha, S., & Gursahani, R. (2023). Simplified Legal Procedure for End-of-life Decisions in India: A New Dawn in the Care of the Dying? *Indian Journal of Critical Care Medicine*, 27(5), 374–376.

10 Justice K.S. Puttaswamy (Retd.) v. Union of India, (2017) 10 SCC 1; see also subsequent constitutional scholarship on decisional privacy and bodily autonomy.

11 Mani, R. K., Bhatnagar, S., Butola, S., Gursahani, R., Mehta, D., Simha, S., et al. (2024). Indian Society of Critical Care Medicine and Indian Association of Palliative Care Expert Consensus and Position Statements for End-of-life and Palliative Care in the Intensive Care Unit. *Indian Journal of Critical Care Medicine*, 28(3), 200–250.

right to life includes the idea of living with dignity and observed that the process of dying may, in appropriate circumstances, raise distinct questions concerning dignity. This conceptual distinction became the foundation for later end-of-life jurisprudence.

The significance of *Gian Kaur* is therefore greater than its rejection of a general right to die. It separated two propositions that had previously been conflated: an individual cannot claim an unrestricted constitutional right to terminate life, but the Constitution may nevertheless protect the manner in which the end of life is approached. The later doctrine of dying with dignity developed within this conceptual space.

Aruna Ramachandra Shanbaug and the Emergence of Passive Euthanasia

Aruna Ramachandra Shanbaug v Union of India represented the next major stage. Aruna Shanbaug had remained in a persistent vegetative state for decades following a violent assault. The Supreme Court was required to consider whether life-sustaining treatment could be withdrawn and what safeguards should govern such a decision.

The Court distinguished active from passive euthanasia and accepted that withholding or withdrawal of life-sustaining treatment could be permissible in specified circumstances. Judicial supervision and medical assessment were treated as safeguards against abuse, particularly because the patient was incapable of expressing a contemporaneous choice.

Medical scholarship has subsequently criticised the terminology of 'passive euthanasia', arguing that withholding or withdrawing medically non-beneficial treatment is better understood as allowing natural death rather than as euthanasia.¹² The distinction is not merely semantic: it influences how clinicians perceive their ethical duties and how families understand the legal status of treatment-limitation decisions.

The practical difficulties created by the earlier judicial procedure eventually contributed to the litigation that culminated in *Common Cause*. The evolution demonstrates how constitutional doctrine and clinical realities interact: legal safeguards must protect vulnerable patients without making ethically justified treatment decisions practically impossible.

Common Cause: Constitutional Recognition of the Right to Die with Dignity

Common Cause (A Registered Society) v Union of India is the central constitutional decision on end-of-life autonomy in India. The Constitution Bench recognised the right to die with dignity as part of Article 21 and accepted the legal validity of advance medical directives.¹³

The decision did not legalise active euthanasia. Instead, it recognised that a person may have a constitutionally protected interest in refusing unwanted medical treatment and that, under specified circumstances, life-sustaining treatment may be withheld or withdrawn. The Court thereby located end-of-life decision-making within the broader constitutional doctrines of dignity, privacy and autonomy.

12 Indian Society of Critical Care Medicine & Indian Association of Palliative Care. (2014). End-of-life care policy for the dying: Consensus position statement of Indian Association of Palliative Care. *Indian Journal of Palliative Care*, 20(3), 171–181.

13 *Common Cause (A Registered Society) v. Union of India*, (2018) 5 SCC 1.

The recognition of advance medical directives is particularly important. An advance directive allows a competent person to communicate treatment preferences for a future period of incapacity. It can therefore be understood as autonomy extended through time. The person who executes the directive determines, while competent, how treatment should be approached if capacity is later lost.

The original procedural requirements were criticised as cumbersome and difficult to implement. In 2023, the Supreme Court modified the procedure, replacing aspects of the earlier mechanism with a more workable medical-board process. Contemporary clinical literature considers the revised procedure an important step toward practical implementation.¹⁴

Harish Rana v Union of India (2026): Refining the Law

The Supreme Court's decision in *Harish Rana v Union of India*, 2026 INSC 222, delivered on 11 March 2026, represents the most recent major development in Indian passive-euthanasia jurisprudence. The official Supreme Court summary identifies three central issues: whether clinically assisted nutrition and hydration (CANH) constitutes medical treatment capable of lawful withdrawal; the meaning and scope of the best-interests principle; and the directions necessary where unanimous medical opinion confirms an irreversible vegetative state and continued CANH offers no therapeutic benefit.¹⁵

Harish Rana is significant because it applies the principles developed in *Common Cause* to a concrete clinical situation involving prolonged irreversible incapacity. It demonstrates that the legal category of life-sustaining treatment must remain responsive to developments in medical technology. Artificial nutrition and hydration may be understood as medical treatment when they are delivered through clinical means for the purpose of sustaining a patient.

The decision also reinforces the distinction between active euthanasia and withdrawal of treatment. The Court did not establish a general right to active euthanasia. Instead, it considered whether continued medical intervention should remain legally mandatory when the patient's condition is irreversible and the treatment no longer provides therapeutic benefit.

The case also highlights the difficulty of applying autonomy when the patient cannot communicate. In such cases, previously expressed wishes, medical evidence, family consultation and the best interests of the patient become central. The 2024 ISCCM-IAPC consensus similarly emphasises shared decision-making, advance directives and best-interests analysis for patients without decision-making capacity.¹⁶

14 Mani, R. K., Simha, S., & Gursahani, R. (2023). Simplified Legal Procedure for End-of-life Decisions in India: A New Dawn in the Care of the Dying? *Indian Journal of Critical Care Medicine*, 27(5), 374–376.

15 Supreme Court of India. (2026). *Harish Rana v. Union of India*, 2026 INSC 222 (11 March 2026). The official landmark-judgment summary identifies passive euthanasia, withdrawal of clinically assisted nutrition and hydration, and the best-interest principle as central questions.

16 Mani, R. K., Bhatnagar, S., Butola, S., Gursahani, R., Mehta, D., Simha, S., et al. (2024). Indian Society of Critical Care Medicine and Indian Association of Palliative Care Expert Consensus and Position Statements for End-of-life and Palliative Care in the Intensive Care Unit. *Indian Journal of Critical Care Medicine*, 28(3), 200–250.

Harish Rana therefore should be understood as a refinement of Common Cause rather than a doctrinal break. It moves Indian law toward greater clinical specificity while retaining the constitutional commitment to dignity and procedural safeguards.

6. Medical Ethics in Palliative Care: The Role of Advance Medical Directives and Advance Care Planning

End-of-life jurisprudence cannot be separated from palliative care. Palliative care aims to relieve pain and other distressing symptoms while supporting quality of life and the psychosocial and spiritual needs of patients and families. Where palliative services are weak, families may experience treatment limitation as a choice between prolonged suffering and death rather than as one element of a comprehensive continuum of care.

Recent Indian evidence demonstrates both the need for and the uneven availability of palliative services. A 2023 systematic review and meta-analysis estimated substantial population-level need for palliative care in India, with regional and urban-rural variation.¹⁷ A 2022 participatory action research project involving Indian cancer treatment centres demonstrated that training, infrastructure and opioid availability can materially improve palliative-care capacity.¹⁸

Observational research published in 2024/2025 also identified futile treatment and barriers to good end-of-life care in a tertiary cancer centre, concluding that communication and palliative-care support can reduce inappropriate aggressive treatment.¹⁹ A 2024 narrative review similarly documented the continuing need to integrate palliative and end-of-life care into cancer services.²⁰

These findings strengthen the argument that the right to die with dignity should not be detached from the right to receive appropriate end-of-life care. Constitutional dignity requires more than permission to discontinue treatment; it requires access to symptom relief, communication, emotional support and humane care.

Advance medical directives are among the clearest expressions of constitutional autonomy in the end-of-life context. They enable individuals to make decisions while competent concerning circumstances in which they may later lack decision-making capacity.

Indian scholarship following Common Cause has emphasised that advance care planning is broader than merely executing a legal document. It involves conversations about values, goals of care, preferred treatment and the circumstances in which treatment should be limited. A 2023 narrative review of advance care planning in India noted that implementation depends

17 Chandra, A., Debnath, A., & Nongkynrih, B. (2023). Palliative Care Need in India: A Systematic Review and Meta-analysis. *Indian Journal of Palliative Care*, 29(4), 375–387. https://doi.org/10.25259/IJPC_140_2023.

18 Rao, S. R., Salins, N., Goh, C. R., & Bhatnagar, S. (2022). Building palliative care capacity in cancer treatment centres: A participatory action research. *BMC Palliative Care*, 21, 101. <https://doi.org/10.1186/s12904-022-00989-2>.

19 Maurya, B. P., Gupta, R., Rathore, P., Mishra, S., Bharati, S. J., Kumar, V., Gupta, N., Garg, R., & Bhatnagar, S. (2025). End of Life Care Practices at a Tertiary Cancer Centre in India: An Observational Study. *American Journal of Hospice & Palliative Medicine*, 42(5), 477–482. <https://doi.org/10.1177/10499091241268585>.

20 Salins, N., Rao, K., Damani, A., Bhatnagar, S., & Simha, S. (2024). Palliative and end-of-life care initiatives for people dying from cancer in India: A narrative review. *ecancermedicalscience*, 18, 1822. <https://doi.org/10.3332/ecancer.2024.1822>.

heavily on civil society and the palliative-care sector, while public and professional awareness remains essential.²¹

A 2024 article on death literacy and advance care planning argues that awareness of the legal right to choose end-of-life treatment should be treated as a public-health concern.²² More recent work proposing a 12-step pathway for advance care planning in India similarly seeks to integrate legal, ethical, cultural and clinical considerations into implementation.²³

The importance of advance directives lies not only in protecting autonomy but also in reducing uncertainty for families and clinicians. They can prevent substituted decision-makers from having to infer a patient's wishes under emotionally difficult circumstances. At the same time, directives must be interpreted carefully, particularly where medical circumstances differ substantially from those contemplated when the directive was executed.

7. The Indian Position in Comparative Ethical Perspective

India's legal position is more restrictive than jurisdictions that permit active euthanasia or medical assistance in dying. Comparative scholarship shows that jurisdictions permitting assisted dying typically establish eligibility requirements, procedural review, reporting mechanisms and professional safeguards.²⁴

However, the Indian debate should not be reduced to a simple question of whether India should adopt a foreign model. The availability of palliative care, social support, healthcare financing, disability rights, family structures and cultural understandings of death materially affect the ethical environment in which end-of-life choices are made.

Recent scholarship on medical assistance in dying also demonstrates continuing controversy concerning eligibility, professional participation, social inequality and the relationship between autonomy and structural injustice.²⁵ These concerns reinforce the importance of cautious, context-sensitive regulation.

India's constitutional framework can therefore continue to recognise treatment refusal and withdrawal of medically non-beneficial treatment without necessarily moving toward legalisation of active euthanasia. Such an approach preserves autonomy while maintaining a strong presumption against intentional life-ending intervention.

21 Advance Care Planning in India: Current status and future directions. A short narrative review. (2023). *Zeitschrift für Evidenz, Fortbildung und Qualität im Gesundheitswesen*, 180, 64–67. <https://doi.org/10.1016/j.zefq.2023.04.011>.

22 Advance care planning and the ethical obligation of death literacy as a public health initiative in India. (2024). *Indian Journal of Medical Ethics*. <https://doi.org/10.20529/IJME.2024.048>.

23 Enhancing Advance Care Planning in India through a 12-step Pathway. (2025). *Indian Journal of Critical Care Medicine / related indexed medical literature*. The framework integrates legal, ethical, cultural and clinical considerations following the 2018 Supreme Court decision and the 2023 procedural amendments.

24 Güth, U., McMillan, S., & Battegay, E. (2023). Medical Aid in Dying: Europe's Urgent Medico-Ethical Challenge. *International Journal of Public Health*, 68, 1606538. <https://doi.org/10.3389/ijph.2023.1606538>.

25 Buchbinder, M., & Cain, C. (2023). Medical Aid in Dying: New Frontiers in Medicine, Law, and Culture. *Annual Review of Law and Social Science*, 19, 195–214. <https://doi.org/10.1146/annurev-lawsocsci-110722-083932>.

The comparison between ancient Indian practices and contemporary constitutional jurisprudence is most accurately captured by the phrase normative continuity without doctrinal equivalence. Ancient Indian traditions provide evidence of sustained reflection on death, suffering, renunciation and conscious acceptance of mortality. They do not, however, constitute legal precedents for modern euthanasia.

The source of legitimacy has changed. In the ancient framework, legitimacy was determined through religious duty, spiritual discipline, detachment and the pursuit of liberation. In the modern constitutional framework, legitimacy is determined through rights, consent, dignity, medical evidence and institutional safeguards.

Yet the comparison remains valuable. It demonstrates that the moral significance of dying has long extended beyond the mere fact of biological death. The contemporary language of dignity and autonomy is historically distinct, but it addresses questions that Indian philosophical traditions also treated as morally serious: how should suffering be understood, when may worldly attachment be relinquished, and what makes the manner of death ethically meaningful?

The proper scholarly approach is therefore neither to claim that ancient India 'invented euthanasia' nor to regard ancient thought as irrelevant to contemporary constitutionalism. The more defensible position is that historical traditions provide an intellectual background against which modern constitutional principles can be interpreted without collapsing one normative system into another.

8. Conclusion

Indian euthanasia jurisprudence reflects a gradual transformation in the normative understanding of voluntary death. The constitutional trajectory from P. Rathinam to Gian Kaur, Aruna Shanbaug, Common Cause and Harish Rana demonstrates that the Supreme Court has moved away from the idea of a general right to die while recognising a limited constitutional right to die with dignity.

The distinction between active euthanasia and withdrawal or withholding of life-sustaining treatment remains central. The Constitution does not presently establish a general right to active euthanasia or physician-assisted suicide. It does, however, protect autonomy and dignity in circumstances where a competent person refuses treatment and permits the withdrawal or withholding of life-sustaining intervention subject to safeguards.

The historical comparison with *sallekhana* and *prayopavesa* adds a further dimension. Ancient Indian traditions engaged deeply with mortality, detachment, suffering and the conscious acceptance of death, but their religious and philosophical purposes were fundamentally different from contemporary medical euthanasia. Their relationship with modern law should therefore be characterised as historical and normative rather than doctrinal.

Harish Rana confirms that the law must continue to adapt to developments in medical technology and clinical practice. Its treatment of clinically assisted nutrition and hydration, irreversible vegetative states and the best-interests principle illustrates the continuing task of balancing dignity, autonomy, medical judgment and protection of vulnerable persons.



Ultimately, the most defensible constitutional approach is one that refuses both extremes: neither must biological existence be prolonged regardless of the patient's wishes and medical circumstances, nor should autonomy be transformed into an unrestricted entitlement to medically caused death. A humane legal order must preserve life, respect informed choice, prevent coercion and ensure access to palliative care. In this sense, the evolution of Indian euthanasia law is best understood as a movement from spiritual legitimacy to constitutional legitimacy, while retaining a continuing concern with the dignity of the human person at the threshold of death.

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