

Right to Die with Dignity: Karnataka's Progressive Model

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REVISITING THE RIGHT TO DIE WITH DIGNITY A CRITICAL LOOK AT KARNATAKA'S PROGRESSIVE APPROACH TO AUTONOMY



Revisiting the Right to Die with Dignity

Introduction

The right to life and personal liberty is recognised as a fundamental right under [Article 21](#) of the Indian Constitution. It is important to note that [Article 21](#) has been interpreted quite inclusively by the Indian Supreme Court, reading into its ambit various rights such as the right to [shelter](#), right to [food](#), right to [privacy](#) and even the [right to be free from the impacts of climate change](#). Importantly, in [Common Cause v. Union of India \(2023\)](#), the Supreme Court clarified that although the right to life does not include the [right to die](#), it does include, within its scope, the right to die with dignity.

The Supreme Court, in the landmark case of [Aruna Ramchandra Shanbaug v. Union of India \(2011\)](#), held that in the case of a permanent vegetative state, passive euthanasia could only be performed after a recommendation by a state-approved and High Court-sanctioned medical board for withdrawal of life-sustaining treatment. However, it is important to note that at this stage, the court did not recognise the legal possibility of individuals administering a “living will,” under which one can state a desire not to receive life-sustaining treatment in an end-stage terminal condition. Seven years later, in [Common Cause v. Union of India \(2018\)](#) right to die with dignity was recognised as a component of the broader right to life. Importantly, the Supreme Court allowed “living wills” or “Advance Medical Directives (AMD).” The case notes a paradigm shift in the Indian jurisprudence in terms of end-of-life decisions, giving people more agency over their deaths. Common Cause went a step further in recognising the legal position of passive euthanasia, which had only been suggested as a possibility by Aruna Shanbaug. While Aruna Shanbaug allowed passive euthanasia under limited circumstances subject to the recommendation by a state-approved and High Court-sanctioned medical board, Common Cause entrusted individuals with the power to refuse life-support treatment in advance, thereby securing greater autonomy and a more lucid statutory setting for end-of-life decision-making.

In 2024, Karnataka implemented the Supreme Court’s directive on the right to die with dignity, enabling terminally ill patients to withdraw life support through a regulated process involving medical boards and judicial oversight. While [passive euthanasia](#) is legally recognised in India, interpretational ambiguities persist, raising critical questions about the implementation of the *Common Cause* directive. In this light, the authors intend to discuss the potential difficulties in interpreting the scope and the resulting implementation of the *Common Cause* directive on the right to die with dignity.

Karnataka’s Implementation of the Right to Die with Dignity: Critical Analysis

An important development in Common Cause was the judgment’s laying down of guidelines for passive euthanasia and Advance Medical Directives, but these were considered cumbersome. Thus, on January 24, 2023, the Supreme Court, in [Miscellaneous Application No. 1699 of 2019 in Writ Petition \(Civil\) No. 215 of 2005](#), simplified the guidelines for passive euthanasia and the execution of Advance Medical Directives to make the process easier and less burdensome for the patients and their families. On January 30, 2025, Karnataka [issued a circular](#) enforcing the Supreme Court’s 2023 directive on Advance Medical Directives and withdrawal of life-sustaining treatment for patients who are “not expected to benefit from life-sustaining treatments.” The process requires consent from next of kin, approval by the treating doctor, and authorisation from medical boards, with records submitted to a Judicial Magistrate. Karnataka, the second state after [Kerala](#), marks a progressive shift toward respecting autonomy and dignity in end-of-life care.

In a [study of 81 nations](#), experts rated the Quality of Death and Dying in 2021. India ranked 59th, which is not a particularly impressive figure. [Another study](#) highlights a substantial need to improve palliative care in India. The [Lancet Commission \(2022\)](#) reports that less than 2 per cent of Indians have palliative care access, leaving many terminally ill patients without support. This lack may make euthanasia seem the only option. Therefore, first, a policy must address such healthcare inequalities, and thereafter, Karnataka could enact its own law to ensure clarity and ethical practice. For alleviating misuse of the *Common Cause* directive, Karnataka should expedite investment in the expansion of palliative care services to provide adequate pain relief and comfort care to patients, making euthanasia less of an alternative in the absence of such care. Public education about end-of-life options, patient rights, and the importance of advance directives is essential for informed decision-making. Additionally, the authors suggest psychological evaluations should be mandated for all cases undergoing euthanasia. In this regard, India could look up to [Oregon's Death With Dignity Act](#) (DWDA). Under DWDA, though psychological evaluations are not automatically mandated for all cases, they are required when either the attending or consulting physician believes the patient's judgment may be impaired by a psychiatric or psychological disorder, such as depression. In such cases, the patient must be referred to a state-licensed psychiatrist or psychologist for counselling. No life-ending medication can be prescribed until the mental health professional determines that the patient is not suffering from a disorder causing impaired judgment.

Procedural Hurdles and the Risk of Judicialisation: A Critique of Karnataka's Model

Karnataka has made a wonderful attempt at operationalising autonomy through its [circular](#), but on closer scrutiny of the procedural setup, the circular unearths many hurdles. The procedure for obtaining necessary approvals from a treating doctor, a board of medical doctors, and finally reporting to a Judicial Magistrate is complex and challenging, particularly for individuals who are often in a state of profound distress. Furthermore, this method may be exceedingly burdensome in rural areas, where access to proficient medical boards composed of specialised physicians and legal authorities could be significantly limited for patients involved in this procedure. Another issue is the widespread backlog in administration. The obligation to convene the medical board and submit documents to the judiciary solely for reporting purposes introduces bureaucratic delays into a time-sensitive process. For the terminally ill patient, enduring extreme pain and having already lost most of their functional capacity, the slow process of approval results in additional waiting time that compounds their suffering; thus, the right to die with dignity becomes a theoretical rather than a practical reality. When a very intimate medical decision, already delicate in nature, ends up being a very long administrative quasi-judicial one, one could call it "judicialisation of death."

Furthermore, the circular does not provide any details on the criteria against which the board would base its decision. For example, how to determine that a patient is "not expected to benefit from life-sustaining treatments" Different members of the medical community may have

different views regarding this prognosis, and this could lead to inconsistency in the process... The circular mentions that “if there is no valid AMD, the surrogate will be the next of kin (family) or the next friend or guardian (if any) of the patient.” This becomes another critical area of exposure. Given the strong realities of familial pressures in this society *vis-a-vis* inheritance and caregiving burdens, this is going to be a provision susceptible to abuse by relatives with bad ulterior motives in the name of quickening death to the patient.

Conclusion

While the recent recognition of passive euthanasia and the legal provision for living wills in Karnataka represents a significant stride toward ensuring individual autonomy in end-of-life decisions, its successful implementation requires more than clear legislation. It requires a multifaceted approach that integrates robust healthcare infrastructure, robust ethical safeguards, and comprehensive public education. By addressing domestic challenges and drawing lessons from international experience, Karnataka can build an ethical, compassionate, and sustainable framework for end-of-life care.