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"IS PROLONGING LIFE ALWAYS CONSTITUTIONAL?" – RETHINKING THE SANCTITY OF LIFE DOCTRINE IN INDIA

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1. ABSTRACT

The evolution of modern medicine has transformed death from an inevitable biological event into a prolonged, technologically mediated process. In India, this transformation has created a profound constitutional dilemma: whether the right to life under Article 21 mandates the indefinite preservation of biological existence, even when such preservation no longer serves any meaningful human purpose. This paper examines the constitutional validity of prolonging life through medical intervention in circumstances where treatment has lost therapeutic value and instead perpetuates suffering, dependency, and loss of dignity.

Drawing upon doctrinal legal analysis, ethical reasoning, and judicial developments, the study interrogates the traditional sanctity of life doctrine and its continued relevance in contemporary end-of-life care. It argues that the Constitution does not compel the mechanical extension of life through invasive technologies when such extension conflicts with the values of dignity, autonomy, and proportionality. Through an engagement with landmark decisions such as Gian Kaur v. State of Punjab, Aruna Ramachandra Shanbaug v. Union of India, and Common Cause v. Union of India, the paper demonstrates a gradual judicial shift from an absolutist protection of life to a more nuanced recognition of dignified dying.

Ultimately, the study concludes that prolonging life is not inherently constitutional. Its legitimacy depends on whether it retains a therapeutic purpose, respects the will and dignity of the individual, and operates within a framework of lawful and compassionate decision-making. The Constitution, properly understood, protects not mere existence, but meaningful human life.

2. KEYWORDS: Human dignity, Article 21, medical futility, end-of-life care, life-sustaining treatment, constitutional morality, autonomy, passive euthanasia, India, proportionality.

3. INTRODUCTION

There are moments in human existence where law finds itself standing silently beside the hospital bed, uncertain of its own authority. In the quiet hum of machines sustaining breath and pulse, the question arises with unsettling clarity: is the preservation of life always a constitutional duty, even when life itself has receded into suffering, silence, and irreversibility? The answer to this question cannot be found in medicine alone, nor in law in isolation. It emerges only at the uneasy intersection of law, ethics, and human experience.

The question of whether life must always be prolonged is not merely a legal inquiry; it is deeply human, rooted in the lived realities of illness, vulnerability, and the quiet erosion of self that often accompanies terminal conditions. In contemporary medical practice, death is no longer an event that arrives naturally and swiftly. It is frequently delayed and managed through a complex network of interventions that sustain bodily functions even in the absence of recovery. Ventilators breathe for failing lungs, feeding tubes replace nourishment, and machines replicate functions once performed by the body itself. Yet, in this technological extension of life, the essence of living—consciousness, agency, and relational presence—may slowly disappear.

The Indian constitutional framework, through Article 21, promises the protection of life and personal liberty. Over time, this guarantee has been interpreted expansively to include dignity, autonomy, and the right to live meaningfully. However, this very expansion creates tension when life-sustaining treatment continues despite the absence of therapeutic purpose. The law must then confront a difficult question: does the right to life require the continuation of treatment even when it prolongs suffering rather than alleviating it?

In many instances, the continuation of treatment reflects not the patient's will, but the combined weight of familial expectations, medical caution, and legal ambiguity. The absence of clear boundaries often results in a default commitment to "do everything possible," even when such efforts merely extend the process of dying. This raises a troubling possibility—that the law, in its attempt to preserve life, may inadvertently compel a form of medical overreach that undermines dignity. Although the distinction between non-initiation and discontinuation has practical implications, it is not reasonable to treat it as a moral chasm. In both cases the same issue is at stake: whether further or anticipated intervention is reasonable. Once a treatment is no longer considered to have a therapeutic purpose, the reasoning is the same for both starting and stopping a treatment. Emotional bias seems to associate more with discontinuation cases, for there is an overt action. Legal reasoning should disregard this bias where it has the potential to distort the reasoning. It is the indication, consent, burden, and purpose of the intervention that is relevant, not the mere timing of the clinical decision.

Control over a person's body is still a baseline limit on clinical power. Invasive procedure; repeated suctioning, tube insertion, restraints, and prolonged mechanical ventilation interventions impact more than anatomy, they impact legal personhood as well. This applies to the other extreme as well, which is of course, avoiding the invasive procedure.

Stephen Wilkinson, Eve Garrard, "Bodily Integrity and the Sale of Human Organs", 22 Journal of Medical Ethics 334 (1996).

It does not seek to diminish the value of life, but to question whether its preservation must always take the form of prolonged biological existence. The questions posed are examined from the perspective of the Preamble of the Constitution of India, the National Medical Commission Act of 2019, the Code of Medical Ethics Regulations of 2002, the operational Guidelines of the Indian Council of Medical Research, and the National Programme for Palliative Care. It also considers the existing position of the Supreme Court of India on advance medical directives and the withholding or withdrawing of medical treatment, as well as the ethical approach concerning the differentiation between the limitation of treatment and the cessation of life. It argues that the Constitution does not exist to sustain life at any cost, but to protect the individual whose life is at stake. In doing so, it invites a rethinking of the sanctity of life doctrine, urging a shift from absolute preservation to a more humane and balanced understanding rooted in dignity and autonomy.

4. MATERIALS AND METHODS

This study adopts a doctrinal methodology grounded in the analysis of constitutional provisions, statutory frameworks, judicial decisions, and ethical scholarship. Article 21 of the Constitution of India serves as the central normative foundation, guiding the inquiry into the meaning and limits of the right to life. Legislative instruments such as the National Medical Commission Act and the Code of Medical Ethics provide insight into the regulatory framework governing medical practice, while guidelines issued by the Indian Council of Medical Research illuminate the evolving standards of end-of-life care.

Judicial interpretation plays a pivotal role in shaping the contours of this inquiry. The trajectory of constitutional thought is traced through key decisions, beginning with Gian Kaur v. State of Punjab, where the Supreme Court reaffirmed the sanctity of life while recognising dignity as an intrinsic component of that right. This evolution continues through Aruna Ramachandra Shanbaug v. Union of India, which cautiously introduced the permissibility of passive euthanasia, and culminates in Common Cause v. Union of India, where the right to die with dignity was explicitly recognised.

The study also engages with bioethical scholarship to explore concepts such as medical futility, autonomy, and best interests. The methodology remains analytical and interpretative, focusing on conceptual clarity and normative reasoning rather than empirical investigation. By situating legal doctrine within its ethical and social context, the study seeks to provide a comprehensive understanding of the constitutional limits of life-prolonging treatment.

5. RESULTS AND DISCUSSION

The historical evolution of end-of-life decision-making in India reflects a gradual shift from unquestioned preservation of life to a more nuanced recognition of dignity. In earlier times, death occurred within the natural rhythm of life, largely untouched by technological intervention. Different time periods emphasized and framed the issues surrounding euthanasia according to the values that dominated that time period. In one time period, the debate may have been dominated by arguments regarding civic honour. In another time period, the debate may have been dominated by arguments based on divine command, while in more contemporary periods, the debate may have been dominated by arguments based on autonomy, and dignity, and calls for the exercise of clinical discretion. In the Indian context, the historical record indicates progress from the penal suspicion that was inherited, to a more focused penal concern with the lawful withdrawal of treatment in cases of irreversible and terminal conditions. This movement, however, did not erase the protective role of the criminal law. Rather, it shifted the focus from direct causation of death to issues of consent, capacity, medical futility, surrogate decision making, and the control of the process.

However, the advent of advanced medical technologies transformed dying into a prolonged process, raising new ethical and legal dilemmas. The ability to sustain life indefinitely brought with it the question of whether such sustenance should always be pursued, regardless of its consequences.

This tension found early expression in Gian Kaur v. State of Punjab, where the Supreme Court upheld the sanctity of life while acknowledging that dignity forms an essential part of that right. Although the Court rejected the idea of a right to die, it left open the possibility that dignity might influence end-of-life decisions.This did not determine the legality of withdrawing life sustaining treatment, but it did provide the basis for subsequent Indian end-of-life case law. It is important for maintaining the constitutional separation between suicide and allowing death to occur when dignity and terminal illness intersect. This subtle recognition laid the foundation for future developments.

The realities of prolonged medical existence were brought into sharper focus in Aruna Ramachandra Shanbaug v. Union of India, where the Court permitted passive euthanasia under strict safeguards.The Court further differentiated between active euthanasia, which is deemed to be unlawful, and the withdrawal of life sustaining treatment when the continuation of treatment does not serve any therapeutic purpose. Thus, the judgment made judicial approval via the High Court a necessary safeguard to the medical practice in India until legislation is enacted. The decision has been viewed as the first legal attempt in India to provide a structured framework to the medical practitioners as to the withdrawal of life sustaining treatment and to recognize medical futility as one of the end-of-life issues that can be addressed within the Indian Constitution and the Common Law of India.The case revealed the human cost of sustaining life in a state devoid of awareness and recovery, prompting a reconsideration of the absolute nature of life preservation. The Court's decision reflected an emerging understanding that the withdrawal of life support, in certain circumstances, may not constitute a violation of the right to life. Sheila A.M. McLean, Assisted Dying: Reflections on the Need for Law Reform 189 (Routledge-Cavendish, Oxford, 1st edn., 2007). Anna Smajdor, Jonathan Herring, et.al., Oxford Handbook of Medical Ethics and Law 212 (Oxford University Press, Oxford, 1st edn., 2022).

This evolution reached a significant milestone in Common Cause v. Union of India, where the Supreme Court formally recognised the right to die with dignity.The decision did not grant new, independent liberty to end one's life by any means. Ultimately, the Court's analysis intertwined bodily autonomy, right to refuse treatment, and right to die with dignity, within a framework of law and coupled with emphasis on constraints. The Court regarded withdrawal of artificial life support as a medical decision that is subject to constitutional scrutiny, which is also a call for procedural safeguards to guard against wrongful relinquishment of control, abuse, or substituted judgment. By validating advance directives and affirming the right to refuse treatment, the Court acknowledged that autonomy and dignity extend into the final stages of life. It showed that the legal pathway to end of life authorization was not limited to the civil legal approach of case law on end of life judicial review. It was a definitive answer to the question of how to structure a legal approach to end of life practice. This judgment represents a shift towards a more compassionate constitutional framework, one that respects the individual's right to determine the course of their own dying.

Despite significant judicial advancements in recognising dignity at the end of life, the practical reality of decision-making in clinical settings remains deeply complex and often troubling. The process is rarely guided by clear legal principles alone; instead, it is shaped by an interplay of fear, uncertainty, emotional strain, and institutional limitations. Physicians, bound by professional responsibility and often apprehensive about legal consequences, tend to err on the side of continuing treatment. This inclination is not always rooted in medical necessity, but in a defensive approach to avoid potential liability or accusations of negligence. As a result, treatment is prolonged even when its benefits are uncertain or negligible.

Families, too, play a decisive role in this process, yet their decisions are frequently influenced by emotional distress, cultural expectations, and an inherent reluctance to accept the finality of death. The act of consenting to the withdrawal of life-sustaining treatment is often perceived as morally equivalent to giving up on the patient, creating an internal conflict that delays rational decision-making. In many cases, patients themselves are unable to express their wishes due to loss of consciousness or cognitive capacity, leading to a complete absence of their voice in decisions that most directly affect them. This silence creates a vacuum, which is often filled by assumptions, anxieties, and external pressures.

In such circumstances, the continuation of life-sustaining treatment is not necessarily the result of deliberate choice, but rather a consequence of hesitation and lack of clarity. The absence of structured decision-making frameworks and effective communication between doctors and families further exacerbates the situation. Conversations about prognosis, quality of life, and the limits of treatment are often delayed or avoided, leaving critical decisions unaddressed until they become unavoidable.

This reality raises a fundamental concern: life is frequently prolonged not because it serves a meaningful purpose, but because there is no clear mechanism to decide otherwise. The gap between legal recognition and practical implementation thus becomes evident, highlighting the urgent need for clearer guidelines, better communication, and a more patient-centred approach to end-of-life care.

When these practices are examined through the lens of constitutional values, particularly under Article 21, they raise serious and unavoidable concerns. The right to life, as interpreted by Indian constitutional jurisprudence, cannot be confined to the mere continuation of biological processes. It is a right that encompasses dignity, autonomy, and the ability to exist in a manner that reflects human worth. To reduce life to a state of mechanical survival, sustained solely by technological intervention, is to strip it of the very qualities that the Constitution seeks to protect.

Medical futility becomes a critical concept in identifying the point at which treatment ceases to serve its intended purpose. It signifies a stage where medical intervention no longer offers a reasonable prospect of recovery or improvement, and instead merely prolongs the dying process. At this juncture, the continuation of treatment raises serious ethical and constitutional questions. If an intervention no longer contributes to the patient's well-being, its persistence cannot be justified solely on the basis that it sustains life in a biological sense.

The principle of autonomy further strengthens this position by recognising the individual's right to make decisions regarding their own body and medical treatment. This includes the right to refuse or discontinue treatment, even when such refusal may result in death.

Autonomy affirms that the patient is not merely a passive recipient of care, but an active participant whose values, preferences, and sense of dignity must be respected. In situations where the patient lacks decision-making capacity, surrogate decision-making must attempt to reconstruct the patient's wishes, rather than impose external judgments based on convenience, emotion, or social pressure.

Complementing autonomy is the principle of best interests, which requires a careful evaluation of the benefits and burdens of continued treatment. This involves considering not only the likelihood of recovery, but also the physical pain, psychological distress, and overall quality of life associated with ongoing intervention. Treatment that imposes significant suffering without corresponding benefit cannot be regarded as being in the patient's best interests.

Together, these principles underscore a vital conclusion: the continuation of life-sustaining treatment must be justified not by its ability to prolong existence, but by its alignment with dignity, autonomy, and meaningful human welfare.

Importantly, the withdrawal of life-sustaining treatment does not signify abandonment. It represents a shift from cure to care, where the focus moves towards comfort, dignity, and emotional support. In this transition, the role of medicine changes from prolonging life to easing the process of dying. This approach affirms that dignity is preserved not through technological intervention, but through compassionate care.

The sanctity of life doctrine has long occupied a central position in both moral philosophy and constitutional reasoning, grounded in the intuitive belief that human life possesses inherent and inviolable value. At its core, the doctrine serves as a safeguard against arbitrary deprivation of life, ensuring that the State and its institutions treat life with the highest degree of respect. However, when this doctrine is interpreted in an overly rigid and absolutist manner, it risks losing its moral depth and transforming into a mechanical rule that is disconnected from the realities of human experience. The preservation of life, when reduced to a purely biological imperative, begins to overlook the very conditions that make life meaningful.

A strictly literal application of the sanctity of life doctrine assumes that life must be prolonged in all circumstances, regardless of the quality of that existence or the burdens imposed by continued medical intervention. This interpretation fails to engage with the complex realities of modern medicine, where technology can sustain bodily functions even in the absence of consciousness, recovery, or relational existence. In such cases, the continuation of life is no longer synonymous with the preservation of personhood. Instead, it becomes a process of maintaining physiological activity, often at the cost of dignity, comfort, and autonomy.

From a philosophical standpoint, life cannot be understood merely as the functioning of biological systems. It is intrinsically linked to the capacity for awareness, interaction, and self-determination. When these elements are irreversibly absent, the question arises whether the continued preservation of life serves any meaningful purpose. To insist on prolonging such a state is to prioritise existence over experience, reducing the individual to a passive object of medical intervention rather than recognising them as a bearer of rights and dignity.

Constitutional morality, particularly within the framework of Article 21, demands a more nuanced approach. It requires that the interpretation of the right to life be guided not only by its textual guarantee, but also by the underlying values of dignity, autonomy, and fairness.

This perspective rejects the notion that life must be preserved at all costs and instead emphasises that the manner in which life is sustained is equally important. A life prolonged through invasive and non-beneficial treatment, devoid of awareness or agency, may not align with the constitutional vision of a dignified existence.

The concept of dignity plays a transformative role in this analysis. It shifts the focus from the mere continuation of life to the quality and meaning of that life. Dignity recognises that individuals have a right to be treated as ends in themselves, not as means to uphold abstract principles or institutional practices. When life-sustaining treatment imposes severe physical and emotional burdens without offering a realistic prospect of recovery, its continuation may conflict with this principle. In such circumstances, the rigid application of the sanctity of life doctrine becomes not a protection, but a constraint.

This tension is further illuminated by the principle of autonomy, which affirms the individual's right to make decisions about their own body and medical treatment. Autonomy challenges the assumption that preservation of life must always override personal choice. It acknowledges that individuals may value dignity, freedom from suffering, and control over their own dying process more than the mere extension of biological existence. To disregard these preferences in favour of compulsory treatment is to undermine the very essence of personal liberty.

Moreover, the insistence on prolonging life in all circumstances risks conflating two distinct concepts: preserving life and prolonging the process of dying. The former is a legitimate and necessary objective of medicine and law, while the latter may, in certain cases, serve no meaningful purpose. When treatment ceases to offer therapeutic benefit and merely extends the dying process, its continuation cannot be justified solely on the basis of the sanctity of life. Instead, it must be evaluated in light of proportionality, considering whether the benefits of treatment outweigh its burdens.

A balanced constitutional approach, therefore, requires a departure from absolutism and an embrace of contextual reasoning. It recognises that the value of life lies not only in its existence, but in its capacity to be lived with dignity and meaning. Prolonging life, in this sense, cannot be regarded as inherently constitutional. Its legitimacy depends on whether it serves the interests of the individual, respects their autonomy, and aligns with the broader principles of justice and humanity.

In conclusion, the sanctity of life doctrine must be understood not as an inflexible mandate, but as a guiding principle that operates within the broader framework of constitutional morality. To preserve its true meaning, it must remain responsive to the realities of human suffering, the limits of medical intervention, and the enduring importance of dignity. Only then can the law ensure that in its effort to protect life, it does not inadvertently diminish it.

6. CONCLUSION

When one reflects on the complexities surrounding end-of-life decision-making, it becomes evident that the issue is not confined to legal doctrine or medical capability alone. At its heart lies a profoundly human concern—the question of how life ought to be valued when it reaches its most fragile and uncertain stage. The traditional tendency to treat life as something that must be preserved in all circumstances, without exception, no longer adequately captures the realities shaped by modern medicine. Today, it is possible to sustain the body even when the essence of living—the ability to think, feel, relate, and choose—has faded beyond recovery. In such situations, the law is compelled to confront a difficult but necessary question: is sustaining biological life always equivalent to respecting life itself?

What emerges from this inquiry is a more layered understanding of life as a constitutional and moral value. Life cannot be reduced to a heartbeat maintained by machines or a body kept functioning through intervention. It carries within it a sense of identity, awareness, and dignity that gives it meaning. When these elements are no longer present, or when they can no longer be restored, the continued use of invasive medical treatment begins to lose its moral clarity. Instead of preserving life in any meaningful sense, it may merely extend the process of dying, often accompanied by discomfort, dependency, and emotional strain.

In this context, dignity becomes an essential point of reference. It reminds us that every individual, regardless of their condition, deserves to be treated with respect and sensitivity. Dignity is not only about how one lives, but also about how one is allowed to approach the end of life. It asks us to move beyond extremes—neither abandoning the patient nor overwhelming them with treatment that serves no real purpose. Rather, it encourages a thoughtful balance, one that recognises when care must shift from attempting to cure to ensuring comfort and peace.

Closely connected to this is the idea of medical futility, which helps identify the point at which treatment ceases to be beneficial. This is not an easy determination, nor is it purely technical. It involves judgment, communication, and an honest engagement with the patient's condition and prospects. Acknowledging futility is often emotionally difficult, yet it can be an act of clarity rather than surrender. It allows both families and medical professionals to accept that there are limits to what medicine can achieve, and that continuing intervention is not always the same as providing care.

The role of individual choice also becomes crucial in this discussion. People do not experience illness or suffering in the same way, and what one person may find acceptable, another may not. Respecting this difference is at the core of autonomy. The ability to accept or refuse treatment reflects a deeper understanding that life is personal, and so are the values that shape it. When individuals can no longer express their wishes, the responsibility shifts to those around them to act with honesty and sensitivity, trying to honour what the person would have wanted rather than what others find easier to accept.

At the same time, it is important to recognise the difficulties faced in real-life situations. Decisions about life and death are rarely made in calm or ideal conditions. Families are often overwhelmed with grief and uncertainty, and doctors must navigate between professional responsibility and emotional realities. In such moments, the continuation of treatment may happen not because it is the best course, but because it feels like the safest or least painful decision at the time. This highlights the need for better communication, clearer understanding, and supportive systems that allow decisions to be made with greater confidence and compassion.

Equally significant is the understanding that stopping treatment does not mean giving up on the patient. Care does not end when machines are withdrawn. Instead, it takes on a different form—one that focuses on relieving pain, providing comfort, and ensuring that the person is not left to face the end of life alone. This shift reflects a more humane approach, where the emphasis is not on extending time at any cost, but on making that time as gentle and dignified as possible.

Ultimately, what becomes clear is that the preservation of life cannot be treated as an automatic or unquestioned objective in every circumstance. It must be understood in relation to the individual whose life is being prolonged. A meaningful approach requires looking beyond the surface and asking whether the continuation of treatment truly serves the person, or whether it merely delays what cannot be avoided. This does not diminish the value of life; rather, it deepens it by acknowledging that life is more than existence—it is experience, connection, and selfhood.

In the end, the true measure of any legal or ethical system lies in its ability to respond to human vulnerability with sensitivity and understanding. Protecting life is undoubtedly important, but it must be done in a way that does not overlook suffering or silence the individual at its centre. By recognising the limits of intervention and the importance of dignity, a more compassionate and balanced approach becomes possible—one that respects life not only in its continuation, but also in its natural conclusion.

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