

Autonomy at the End of Life: Legal and Educational Challenges in Implementing Living Wills and Passive Euthanasia in India

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ABSTRACT:

The right to end-of-life autonomy has evolved in India from a peripheral ethical issue to a constitutional question. The apex court of our country has recognised passive euthanasia, advance medical directives as legal manifestations of dignity, bodily integrity and decisional autonomy under Article 21 of the Constitution. This legal recognition has not rendered living wills socially intelligible, clinically usable and accessible for persons with disabilities, older persons, persons with communication barriers and families contending with terminal illness. The paper uses a multi-tiered legal-educational framework to look into the legal and pedagogic issues in India regarding living wills and passive euthanasia. It employs a doctrinal and analytical method founded upon Supreme Court decisions, statutory materials, Law Commission documents, medical ethics guidelines, palliative care literature, the disability rights literature and inclusive education literature. According to this analysis, the Common Cause (2018) constitutionalised the right to end-of-life self-determination, and the 2023 modification simplifies the operations and implementation of advance directives. The 2026 decision in Harish Rana provided additional clarity on the position of clinically assisted nutrition and hydration as treatment and the best-interest standard for people unable to currently express preferences. Though there is effort to implement the Convention, it is hampered by public ignorance, procedural anxiety of health professionals, inaccessible legal-medical phrasing, weak institutional ethics infrastructure, and lack of training to communicate in a disability-inclusive fashion. Unless India builds an ecosystem around legal literacy, supported decision-making, palliative counselling, professional curricula and accessible public communication, living wills are likely to be a formal right than an effective safeguard. A proposed model for developing disability-inclusive policies that balance autonomy and protection from abuse medical ethics and educational preparedness.

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Keywords: advance medical directive; living will; passive euthanasia; Article 21; disability rights; supported decision-making; special education; legal literacy; palliative care; India.

1. Introduction

The question of how a person ought to be allowed to die has become one of the most demanding tests of constitutional morality, medical ethics and public education in India. Choices regarding end-of-life care are seldom made abstractly. They happen in hospital wards, ICUs, homes and long-term care settings where patients, relatives, physicians, nurses and caregivers experience suffering, uncertainty, cost and moral burden. The Indian legal system currently recognises that an adult who has the requisite competence can refuse medical treatment that is unwanted, and also record future wishes through an advance medical directive, or more colloquially, a living will (Common Cause, 2018; Common Cause, 2023). In spite of the above, the gap between judicial recognition and everyday implementation is huge.

This paper seeks to examine living wills and passive euthanasia as not only a medical-law issue but also a legal-educational and disability-rights issue. Although a right may be declared constitutionally, it cannot be claimed effective if the affected people cannot comprehend, convey, execute, store or rely upon professionals who are qualified and trained to execute it. This matter is of great significance for the following groups. These people are persons with disabilities, persons with intellectual or psychosocial disabilities. It also includes persons with speech or communication impairments, older persons with degenerating conditions, terminally ill patients and caregivers. These people mostly rely on institutions to act under the law in practice (United Nations, 2006; WHO & World Bank, 2011).¹

1.1 Conceptualising End-of-Life Autonomy in India

Over the years, the ambit of Article 21 has grown to include not just the right to life but also the right to dignity, privacy, bodily integrity and decisional autonomy, as we see from the ruling in Justice K. S. Puttaswamy (2017). The Supreme

Court in *Gian Kaur v. State of Punjab* (1996) held that there is no constitutional right to commit suicide as such. However, it stated that there may be a right to die with dignity during the natural course of death. This differentiation became essential in the end-of-life law. The Supreme Court of India in *2 Aruna Ramchandra Shanbaug v. Union of India* (2011) allowed passive euthanasia in certain exceptional situations under a judicial framework, whereas *Common Cause* (2018) granted wider constitutional recognition to advance directives. Also, the right to refuse life-sustaining treatment.

The Court has evolved its interpretation to rely less on protecting life at all costs and pay more heed to the dignity of the dying. Nonetheless, this creates new implementation questions. Who interprets the law for patients and families? Without any discriminatory assumptions, how is competence assessed? What assistance is provided to PWDs persons to enable their decision-making? How should doctors perform when there is a disagreement from the family? How to make the living will available in simple language, vernacular language, Braille, audio, or supported communication formats? The questions posed are equally educational and institutional as they are legal.

1.2 Living Wills, Passive Euthanasia, and the Right to Die with Dignity

A living will is also known as an advance medical directive. A competent adult will write a living will which relates to what medical treatment the adult wishes to undergo. In the future, the person might not be able to communicate any decisions. The moral justification comes from prospective autonomy, in that a present, competent self gives instructions to a future, incapacitated self (Sudore et al., 2017). Passive euthanasia denotes the withholding or withdrawal of medical treatment that would otherwise artificially prolong life; active euthanasia is a positive act intended to cause death,

¹Convention on the Rights of Persons with Disabilities, 2006; World Health Organization and World Bank, World Report on Disability, 2011.

²*Gian Kaur v. State of Punjab*, (1996) 2 SCC 648, distinguishing an impermissible right to suicide from the concept of dying with dignity in the natural process of death.

such as administering a lethal substance, which continues to be impermissible in India (Common Cause, 2018; Harish Rana, 2026).³

The legal importance of the distinction is that passive euthanasia is seen as permitting the illness or condition to take its course while active euthanasia causes or hastens death. The Indian courts have retained this distinction as a dividing line between constitutionally protected refusal or withdrawal of treatment affirmed by the Constitution Bench in Common Cause case and prohibited killing. India, therefore, is called upon, not to collapse the distinction, but to make the passive euthanasia safeguards intelligible, accessible and ethically workable.

1.3 Relevance to Disability Rights, Special Education, and Legal Literacy

The subject has great significance for disability rights and special education because exercising end-of-life autonomy depends on communication, understanding, support and respect for legal capacity. The United Nations (2006) Convention on the Rights of Persons with Disabilities states that all persons including disabled persons have legal capacity, and must be given access to support as individuals exercise their legal capacity. The Rights of Persons with Disabilities Act, 2016 in India also mandates a non-discriminatory, accessible and dignified approach. It is essential to apply these principles when patients have communication impairments, intellectual disabilities, psychosocial disabilities or high-support needs.⁴

Legal discourses about passive euthanasia rarely take place in the presence of special educators, rehabilitation professionals, counsellors, social workers and caregivers. However, they often assist individuals with disabilities in expressing their

preferences, comprehending their choices, utilizing communication aids, and navigating family or institutional environments. A disability-inclusive framework necessitates education that goes beyond merely delivering information and includes capacity-sensitive counselling, supported decision-making, accessible formats, and safeguards against coercion (Committee on the Rights of Persons with Disabilities, 2014; Gooding, 2015).⁵

1.4 Research Gap

Indian legal scholars have focused largely on constitutional doctrine, religious morality, physician liability and procedural safeguards regarding passive euthanasia. Medical scholarship has concentrated on intensive-care decision-making, palliative care, and do-not-attempt-resuscitation practices. (ICMR Expert Group on DNAR, 2020; Mani et al., 2024; 6Myatra et al., 2014) Disability-rights literature has separately analysed legal capacity and supported decision-making. Nevertheless, little research brings together these fields into a usable educational framework for the implementation of living wills across populations.

A visible gap is seen mainly due to the non-availability of systematic legal literacy programs, easily accessible advance directive materials, and training modules for non-law professionals, and curriculum integration in law, medicine, nursing, social work, rehabilitation and special education. The Common Cause's simplification of 2023 and Harish Rana judgment of 2026 make the gap more urgent because it brings implementation closer to the clinical setting and requires trained institutions, not courts alone, to take action.

³Harish Rana v. Union of India & Ors., Miscellaneous Application No. 2238 of 2025 in SLP(C) No. 18225 of 2024, 2026 INSC 222.

⁴Rights of Persons with Disabilities Act, No. 49 of 2016, India, requiring equality, non-discrimination and accessibility in the enjoyment of rights by persons with disabilities.

⁵Committee on the Rights of Persons with Disabilities, General Comment No. 1 on Article 12, Equal Recognition Before the Law, 2014; Gooding, Human Rights Law Review, 2015.

⁶Indian Council of Medical Research Expert Group on DNAR, consensus guidelines on Do Not Attempt Resuscitation, Indian Journal of Medical Research, 2020.

1.5 Objectives of the Study

The research focuses on six objectives namely, studying constitutional development of passive euthanasia and living wills in India; to clarify the legal distinction between active and passive euthanasia; to analyse the 2023 simplification of advance directive processes; to evaluate disability-rights implications of decision-making capacity and supported decision-making; to identify educational barriers impacting patients, families and professionals; and to recommend a disability-inclusive policy model for implementation through legal literacy, professional training and accessible communication.

1.6 Research Questions

How has Indian law conceptualised end-of-life autonomy under Article 21? What restrictions do procedural and institutional challenges pose to the use of living wills? The impact of disability rights on capacity, consent and autonomy in end of life decisions What educational measures are needed for caregivers, counsellors, social workers, special educators, legal professionals and health professionals? What can India do to devise safeguards that don't make the right practically unworkable?

2. Review of Literature

The subject and rights discourse on end-of-life autonomy spans multiple disciplines, including constitutional law, bioethics, intensive care medicine and palliative care, disability studies and inclusive education. A coherent review must therefore read these judicial sources, alongside medical guidelines and educational literature. The central insight emerging from these sources is that autonomy is not a single event of signing a document; it is a communicative, relational and institutional process that requires information, time, trust, accessibility and professional competence (Beauchamp & Childress, 2019; 7Sudore et al., 2017).

7Beauchamp and Childress, *Principles of Biomedical Ethics*, 8th edition, Oxford University Press, 2019.

2.1 Constitutional Jurisprudence on Life, Dignity, and Autonomy

The base of the constitution lies in Article 21, the Indian Courts have interpreted it to mean the right to live with dignity and not merely to animal existence. Gian Kaur (1996) does not recognize the right to commit suicide, however, she leaves doctrinal space for dignified dying in terminal circumstances. The Common Cause (2018) ruling further bedded the principles of recognition of the right of a competent individual to refuse unwanted medical treatment and to execute an advance medical directive. Puttaswamy (2017) reinforced this foundation by upholding decisional autonomy as being at the essence of privacy and personhood.

This trend mirrors common-law trends abroad. In *Cruzan v Director, Missouri Department of Health* (1990), the U.S. Supreme Court recognised a protected liberty interest in refusing unwanted medical treatment, while permitting evidentiary safeguards. In the United Kingdom, the case of *Airedale NHS Trust v. Bland* (1993) allowed for the withdrawal of treatment from a patient in a persistent vegetative state. *Montgomery v. Lanarkshire Health Board* (2015) made informed consent more patient-9 10 centred. Comparative jurisprudence shows that autonomy at the end of life is rarely absolute; rather, it is mediated by proof, capacity, medical judgment and procedural safeguards.

2.2 Passive Euthanasia and Advance Directives in Indian Law

The first judicial recognition of passive euthanasia came about in India in the *Aruna Shanbaug* case (2011) however the process was placed under high

8Cruzan v. Director, Missouri Department of Health, 497 U.S. 261 (1990), recognising a constitutionally protected liberty interest in refusing unwanted medical treatment in U.S. law.

9Montgomery v. Lanarkshire Health Board, [2015] UKSC 11, moving informed consent toward a patient-centred disclosure standard in UK medical law.

10Airedale NHS Trust v. Bland, [1993] AC 789 (HL), concerning withdrawal of treatment from a patient in a persistent vegetative state under English law.

court supervision. Common Cause (2018) took a further step ahead in the recognition of advance directives and detailed instructions for execution and implementation. In 2023, the Court modified these requirements in a major way. Earlier, judicial magistrate countersignature was required; this was replaced. Execution can now be done before a notary or gazetted officer. More modifications included clarifying the procedures for the medical board (Common Cause, 2023).

The 2023 change was viewed in a favourable light by medical commentators, with the 2018 approach seen as too convoluted for everyday clinical use (Mani et al., 2023). It was not just an operational issue. If the law requires multiple authorities, dubious documentation and delayed timelines over clinical crises, professionals may choose to avoid implementation or continue treatment against patient will. The ethical practice is affected by legal design.¹¹

2.3 Disability Rights and Decision-Making Capacity

Research on the rights of the disabled disputes the presumption of incapacity as a ground for others to make an individual's decision. In accordance with Article 12 of the CRPD, individuals must possess recognition of legal capacity on an equal basis with others and access to support for exercising legal capacity (United Nations, 2006). General comment No. 1 calls for a transition from substitute decision-making to supported decision-making wherever possible (Committee on the Rights of Persons with Disabilities, 2014). The transition from disease control to comfort enhancement for patients and their families is not straightforward at the end of life. Most importantly, disability rights require clinicians to first ask what support may help enable communication before ruling out participation.¹²

11 Mani, Simha and Gursahani, Simplified legal procedure for end-of-life decisions in India, *Indian Journal of Critical Care Medicine*, 2023.

12 Article 12 of the Convention on the Rights of Persons with Disabilities recognises equal legal capacity and access to support in exercising legal capacity.

Indian law already has partial resources for this approach. The 2017 Mental Healthcare Act lays down standards for advance directives in mental healthcare, with necessary safeguards and reviews with capacity and informed execution. The 13 RPwD Act 2016 promotes dignity, equality accessibility. The end-of-life legislation should not rely on discriminatory presuppositions that people with disabilities have a reduced interest in life, a weakened claim to autonomy and a lesser need for accessible communication (Dhanda, 2007; Series, 2015).

2.4 Legal and Health Literacy in End-of-Life Rights

Health literacy and legal literacy are critical determinants of the significance of a living will. Terms such as passive euthanasia, medical futility, ventilatory support, clinically assisted nutrition and hydration, surrogate decision-maker and best-interest standard may be hard to decipher even for literate adults. Santana et al. (2021) contend that contemporary health literacy must be regarded as an organisational responsibility, rather than as a patient deficiency. An appropriate learning environment must be created for the local community at hospitals, law colleges, medical colleges and community centers so they can really know and use their rights.

The ICMR DNAR guidelines illustrate an effective communication framework by focusing on a) informing patients or surrogates, b) maintaining the continuity of compassionate care, and c) using language understandable to families (ICMR Expert Group on DNAR, 2020). DNAR is not to be confused with passive euthanasia or an advance directive, but the educational principles are the same – an early conversation, explicit and clear explanation, awareness of cultural context, documentation and reassuring . . . to remind that

13 Mental Healthcare Act, No. 10 of 2017, India, includes provisions on advance directives in the mental healthcare context.

14 Santana et al., *Journal of Public Health Management and Practice*, 2021, framing health literacy as an organisational and public-health responsibility.

refusal of futile intervention does not equal abandonment.

2.5 Legal Literacy, Health Education, and Inclusive Communication

The scholarship of inclusive education offers a language for making end-of-life law accessible. UNESCO emphasises participation, the removal of barriers and responsiveness to learner diversity in their inclusion framework. Adapted to living wills, provided the information that is to be made available is in simple language, vernacular, audio, Braille, easy-read formats, sign-language supported counselling and communication boards wherever required. Public legal education cannot be directed only to English-speakers.

education which is profession based equally important. Medical students may learn about anatomy and emergency care but not end-of-life communication. Students of law may study constitutional doctrine without clinical exposure. Special educators might not experience advance care planning when learning disability assessment. The curricula of nursing, social work, and counseling may include meeting ethics involved without legal process. An interdisciplinary curriculum is needed to make constitutional rights real.

2.6 Comparative International Perspectives

the advance care planning depends on the institution's culture, comparatives suggest The U.S. has long recognised advance directives but uneven uptake, racial and socio-economic disparities and uncertainty in surrogate decision making continue (Institute of Medicine, 2015; Sudore et al., 2017). Through the United Kingdom's Mental Capacity Act framework, advance decisions refusing treatment have legal effect, and best-interest reasoning is used for persons lacking capacity. Canada's Carter ruling dealt with physician-assisted dying, which differs from India's passive euthanasia model, but indicates how courts are

framing dignity, autonomy and safeguards in end-of-life debates (Carter, 2015).¹⁵

India's unique challenge is the implementation of advance directives within a context of family-centred decision-making, disparate access to medical care, linguistic diversity, uneven availability of palliative care and uneven legal literacy. We should not try to clone anything imported. We have to construct the educational and procedural structures, reflective of Indian social conditions, without impairing constitutional autonomy.

3. Research Methodology

The methodologies used are doctrinal and analytical legal-educational. The legal aspect studies constitutional provisions, Supreme Court verdicts, statutory instruments and Law Commission reports. The analysis of disability rights materials, literature on inclusive education, scholarship on health literacy, palliative care guidelines, and professional education needs, etc. This research is wholly reliant on secondary sources and does not include primary human-subject data. Consequently, human subjects were not enlisted, personal data were not acquired, and survey outcomes are absent.

The Constitution of India embodies the principles of the common civil code as enshrined in Articles 37 and 44 of the document. It enshrines fundamental principles and values that govern the right to a normal death. It also emphasises the right to life, dignity and privacy as essential components of Article 21. This is evident from the recognition of the living will by the Supreme Court in various verdicts. The analysis employs interpretive synthesis, not statistical testing.

Acknowledgement of the limitations of the study. In the first place, it does not use primary data to measure public awareness or professional readiness. Additionally, the legal implementation is evolving at a rapid pace, especially after Harish Rana (2026) the state-level hospital protocol may change too. Furthermore, the third section of the

¹⁵Carter v. Canada (Attorney General), 2015 SCC 5, addressing medical assistance in dying under Canadian constitutional law.

paper focuses on India, but selectively draws upon comparative sources with a view to finding principles for implementation rather than providing an account of a full-blown comparative law nature. An exploratory perception-based survey among health care professionals, law students, special educators, caregivers and social-work trainees could be conducted as a future empirical phase with being done with informed consent, confidentiality, ethics approval and non-identifiable reporting.

4. Legal Framework Governing End-of-Life Autonomy in India

India's judicially established, constitutionally bolstered and procedurally intricate end-of-life framework is only partially legislated. The regulation goes through Article 21, supreme court judgment, professional medical knowledge and general statutory duties relating to disability, mental healthcare and medical ethics. As it results in flexibility and uncertainty.¹⁶

4.1 Constitutional Basis of End-of-Life Autonomy

Article 21 provides protection to life and personal liberty as per a certain procedure. This guarantee has over the years been interpreted by the Supreme Court as including dignity, privacy, autonomy, bodily integrity and meaningful choice. Common Cause (2018) located the right to refuse medical treatment within this constitutional architecture. The Court found that imposing unwanted treatment on a competent person diminishes their dignity and self-determination. The right is not a right to be killed; it is a right not to be subjected to medical treatment that the person does not want.

The distinction is necessary for the constitutional legitimacy. Active euthanasia or physician-assisted suicide is not allowed in Indian law. Instead, it allows, under safeguards, the withholding or withdrawal of life-sustaining treatment where that treatment would merely prolong the process of

dying or where an advance directive or best interests... The constitutionally relevant focus is autonomy within medical decision-making, not a right to demand death generally.

4.2 Judicial Development from Aruna Shanbaug to Common Cause

In Aruna Shanbaug (2011), the case was that of a nurse who had been in a persistent vegetative state for several decades. The court rejected the specific request for the withdrawal of feeding, as the hospital's caregivers were opposed to it. However, it accepted passive euthanasia in principle under strict judicial supervision. The decision was significant but makes excessive use of procedures; it is also deviant in terms of doctrine. According to Common Cause (2018), the legal status of passive euthanasia, as well as advance medical directives, are grounded in dignity and autonomy under Article 21. Furthermore, the Court recognised that a competent adult has the right to decide in advance whether life-sustaining treatment should be withheld or withdrawn in future circumstances. It generated two pathways: advance directive cases and those without an advance directive. Both were required oversight and medical boards. The changes made in 2023 have made the execution and implementation simple. In this case, there was no advance directive and the patient was in a permanent vegetative state, making best-interest analysis and assessment of clinically assisted nutrition and hydration necessary.

4.3 Advance Medical Directives and Health-Care Planning

An advance medical directive only valid only if made voluntarily by an adult with capacity to understand its nature and consequences. The document must enumerate the conditions under which medical treatment can be withheld or terminated, designate a guardian or relative where appropriate and be changeable while the patient has capacity. With the 2023 amendment, execution before a notary or gazetted officer has made getting the process easier than what was the

¹⁶The Indian framework is primarily judge-made and constitutionally anchored, supplemented by professional medical guidance and disability-rights statutes.

requirement of judicial-magistrate countersignature: Common Cause (2023)¹⁷

Educational problem can't be solved by simplified execution alone. Most people are unaware of the existence of lakh wills. Some people mistakenly think that signing one means refusing all treatment. Some families may worry about criminal liability or social stigma. People with disabilities may need supported communication to understand choices or record decisions. Consequently, the legal document should come along with an aide-memoire, universal design and easy formats.

4.4 Procedural Safeguards and Implementation Barriers

The new 2023 change will not allow life-sustaining treatment to be withheld or withdrawn without institutional medical-board review. The treating hospital generally constitutes the Primary Medical Board which consists the treating doctor and subject experts. According to the adjusted process (Common Cause, 2023), the Secondary Medical Board gives an independent view, which has to be recorded and communicated. In case of misuse, error and conflict, these protections help. But they also mean hospitals must know how to set up boards quickly.

Barriers to implementation are lack of trained board members in small hospitals, uncertainty regarding documentation, limited palliative care access, fear of police or criminal action and absence of state level standard protocol. Vallath et al. (2026), dipanwarakan perintah Mahkamah Agung memerlukan kejelasan prosedur, koordinasi pentadbiran tempatan dan templat institusi. The absence of these infrastructure may make the living wills symbolic rather than usable.

4.5 Role of Medical Boards, Courts, and Family Participation

The clinical competence to decide whether treatment is futile, disproportionate or medically

inappropriate lies with medical boards and not courts. Medical boards also should not view autonomy as simply a clinical judgment of preferable care. They verify the medical condition, assess the applicability of the directive or best-interest standard, document reasons and ensure the continuation of palliative care. It is important to involve family as far as no order, but family wishes cannot just to supplant patient value or rights.

The less intrusive nature of the judicial oversight embedded in the new framework is no bar to the court's ability to review disputes. The aim is to prevent both occurrences: a cumbersome court-centric model that renders the right unexercisable and an unchecked clinical model that is liable to abuse. This equilibrium calls for expert education, institutional moral boards and reachable complaint-covered items.

4.6 Disability, Capacity, and Supported Decision-Making

Capacity is determined by time and support. An individual might be unable to make one complex decision but can make other decisions. A speech impaired person can do everything but talk rather than not being able to speak. A person with an intellectual disability may be able to make choices if the information is provided in an easyread form with trusted support. These distinctions are important because disability cannot be equated to incapacity (Committee on the Rights of Persons with Disabilities, 2014; Flynn & Arstein-Kerslake, 2014).

To establish supported decision-making, it is essential that the individual identifies trusted persons, communication aids, sufficient time for explanation and methods for expressing their preference. It also needs protection against excessive influence. Substituted decision-making should only apply when supported decision-making has been exhausted. In cases where someone is permanently unconscious or otherwise unable to express any present preference, substituted judgment and best-interest reasoning may be necessary. But when they are, such reasoning ought to be informed by values, relationships, medical reality and dignity not mere convenience.

¹⁷Common Cause modification order, Supreme Court of India, 24 January 2023, simplifying execution of advance medical directives and medical-board procedure.

Table 1. Indian judicial and policy developments on passive euthanasia and living wills

Development	Core legal contribution	Disability and educational relevance	Continuing implementation issue
Aruna Ramchandra Shanbaug v. Union of India (2011) ¹⁸	Accepted passive euthanasia in principle under strict judicial supervision, while refusing withdrawal in the facts of the case.	Brought public attention to persons in persistent vegetative state and the need for careful representation of non-communicative patients.	Procedure was court-centred, uncertain and difficult for routine hospital implementation.
Common Cause v. Union of India (2018)	Recognised advance medical directives and the right to refuse life-sustaining treatment as aspects of dignity and autonomy under Article 21.	Created a legal basis for prospective autonomy but required patient and family education to make living wills intelligible.	Initial procedure was complex, requiring multiple authorities and generating implementation hesitation.
Common Cause modification order (2023)	Simplified execution and implementation of living wills, including execution before a notary or gazetted officer and streamlined medical-board review.	Improved practical accessibility but still requires plain-language guidance, accessible formats and professional training.	Hospitals need protocols, trained board members, document custody systems and palliative care pathways.
Harish Rana v. Union of India & Ors. (2026)	Clarified that clinically assisted nutrition and hydration through a PEG tube may be treated as medical treatment/life support in the passive euthanasia framework; applied best-interest reasoning where no advance directive existed.	Highlights the importance of supported decision-making, caregiver education and safeguards for persons unable to express present preferences.	Shows the need for comprehensive legislation, institutional readiness and disability-sensitive assessment in no-directive cases.

¹⁸Aruna Ramchandra Shanbaug v. Union of India, (2011) 4 SCC 454, where the Supreme Court accepted passive euthanasia in principle under a court-supervised framework.

5. Educational Challenges in Implementation

India's living-will framework's biggest weakness is not lacking constitutional recognition but lacking educational infrastructure said the report. A document may be legally valid, yet fail if actors are uninformed about it; if professionals are fearful of using it; if communication excludes those in greatest need of support.

5.1 Public Awareness of Living Wills

Surveys show the public is not very aware of advance medical directives. The legal lexicon in itself can be misleading. Euthanasia is perceived as an active killing, suicide or abandonment. Some may think that family consent on its own is enough for any end-of-life decision. It follows that education must explain that a living will is not a demand for death but a statement about medical treatment when recovery is no longer possible or when treatment only prolongs suffering.

5.2 Patient and Family Legal Literacy

Understanding of laws, also understanding of legal process or institutions. This means being able to handle the situation, taking into account actions and consequences. Workers in residential care often comment on how families can be emotionally overwhelmed during a terminal illness and may be unable to process complex legal information at the bedside. Education on living wills must occur prior to a crisis event, through organisations such as a community health programme, older-adult clinics, disability organisations, legal aid clinics and palliative care services.

5.3 Training Gaps Among Health Professionals

Physicians and nurses often have little formal training in advance care planning, communicating about disability, and the law on withdrawal of treatment. They might over-treat out of liability fear and under-communicate due to under-confidence in EOL discussions. The ICMR DNAR directives highlight the importance of communicating with patients or surrogates, continuing compassionate treatment, and institutional sensitization (ICMR Expert Group on

DNAR, 2020). Similar training is required for living wills and passive euthanasia.

5.4 Role of Special Educators, Social Workers, and Counsellors

Special educators and rehabilitation professionals can assist in capacity-sensitive communication, particularly when patients use non-verbal, aided or alternative communication. Families can be assisted with resource awareness, conflict reduction, and connection to palliative care. Counsellors can assist with dealing with grief, guilt and morality distress. Involving these parties would humanize decision-making at the end of life and not render it solely legalistic or medicalised.

5.5 Communication Barriers for Persons with Disabilities

Individuals with disabilities may encounter obstacles at any stage from comprehending the idea of an advance directive to executing it, to storing the document, to communicating changes, to having professionals comply with it. Information is unavailable in any of the following formats. Braille, large print, sign language, audio or easy-read. Communication boards or interpreters are absent in hospitals. Equal legal capacity is not incidental to these barriers, which are determining in nature.

5.6 Accessibility of Legal and Medical Information

Legal medical info should be accessible in content, form and language. Comprehensible explanations on life-support, artificial ventilation, artificial nutrition, cardiopulmonary resuscitation, palliative care and withdrawal of treatment should be publicly available. It also encompasses several languages used in the region, digital accessibility, formats for low literacy, and culturally sensitive counselling. As per RPwD Act and CRPD such accessibility is part of the rights obligation and not accommodation.

5.7 Curricular Integration in Law, Medicine, Nursing, Social Work, and Special Education

Having a curriculum-based awareness is essential because professionals cannot implement rights they are not trained to understand. Law courses

should include clinical ethics and disability-inclusive legal literacy. The curriculum for medical and nursing schools should contain advance care planning, palliative communication and legal process. End-of-life autonomy, supported decision-making and caregiver counselling should

be part of special education curriculum. The integration of such curricular integration can be facilitated by the National Education Policy's focus on inclusion and interdisciplinary learning (Ministry of Education, 2020).

Table 2. Educational barriers and suggested interventions for implementing living wills

Educational barrier	Risk created	Stakeholders affected	Suggested intervention
Low public awareness of living wills	Rights remain unused or are invoked only during crisis.	Patients, older persons, terminally ill persons, families.	Community legal literacy campaigns, hospital information desks, palliative care counselling and legal aid outreach.
Complex legal-medical language	Misunderstanding of passive euthanasia as active killing or abandonment.	Patients, caregivers, junior doctors, nurses.	Plain-language, multilingual, easy-read and audio-visual explanatory materials.
Inaccessible formats for persons with disabilities	Exclusion from advance care planning and consent discussions.	Persons with visual, hearing, speech, intellectual or psychosocial disabilities.	Braille, large print, sign-language support, augmentative communication and supported decision-making protocols.
Limited professional training	Defensive medicine, over-treatment or procedural non-compliance.	Doctors, nurses, ethics committees, hospital administrators.	Mandatory continuing education on Common Cause, Harish Rana, palliative care and documentation. ¹⁹
Family conflict and caregiver guilt	Delay, moral distress and pressure on physicians.	Families, caregivers, social workers, counsellors.	Family conferences, mediation support, counselling and reassurance that palliative care continues.
Weak institutional protocols	Boards not constituted on time; records remain incomplete.	Hospitals, medical boards, district authorities.	Standard operating procedures, templates, board rosters and audit systems.
Limited curricular	Future professionals	Law, medicine, nursing,	Interdisciplinary

¹⁹The cited decisions represent the principal Supreme Court materials relied upon in the manuscript for the Indian passive-euthanasia and living-will framework.

Educational barrier	Risk created	Stakeholders affected	Suggested intervention
integration	enter practice without competence in end-of-life rights.	special education and social work students.	modules, case simulations, supervised living-will clinics and ethics workshops.

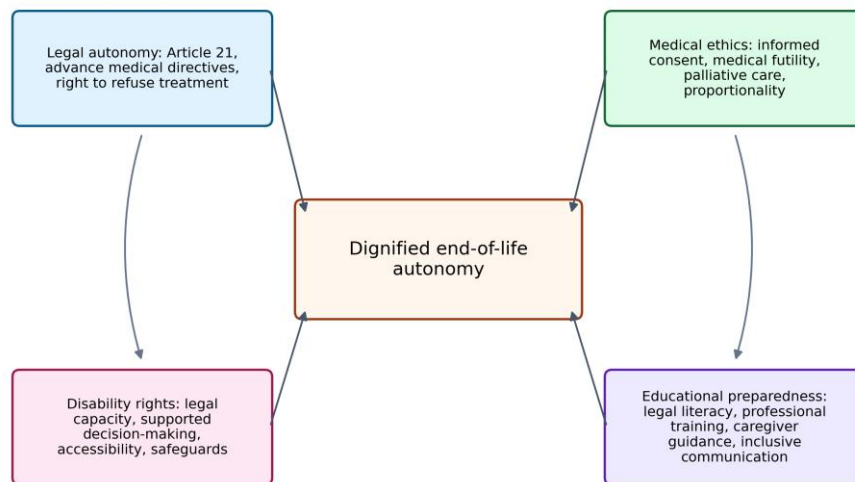


Figure 1. Conceptual framework for disability-inclusive implementation of living wills

The conceptual framework positions dignified end-of-life autonomy at the intersection of legal autonomy, medical ethics, disability rights and educational preparedness. The framework emphasises that each domain is necessary but insufficient alone: legal rights require clinical judgment, clinical judgment requires ethical safeguards, disability rights require accessibility and support, and education enables implementation across institutions.

6. Analysis and Discussion

The framework with which the Indian constitution is endowed is a promise necessitating socialisation. The main pressure is between respect for autonomy and preventing abuse. Law by itself cannot resolve this pressure. Trained institutions and an informed community are also needed.

6.1 Balancing Autonomy and Protection from Abuse

By empowering a person's prior wishes, a living will protects freedom of choice. In addition, it diminishes moral distress in relatives who may otherwise feel guilt on life-sustaining treatment

withdrawal. India's social context requires safeguards against coercion, property-related pressure, gendered neglect, disability discrimination and cost-driven abandonment. Common Cause (2018) implemented medical-board safeguards to address these risks. We must avoid making the procedure so onerous that the privilege cannot be exercised.

6.2 Passive Euthanasia and Medical Futility

Medical futility is when treatment does not offer a reasonable prospect of any meaningful physiological benefit to patient anymore. This does not mean the person's life is a waste. It is the basis of ethics. In passive euthanasia, it is not the value of a patient that matters, but the futility or disproportionality of one intervention. Following the termination of an onerous medical intervention, palliative care should be made available.

6.3 Disability Rights Concerns in End-of-Life Decision-Making

Concern about disability rights arises because societies often underestimate disabled lives. A

framework that allows for the withdrawal of treatment must therefore be careful not to assume that a severe disability equals indignity. The query is not if a disabled life is worth living; rather, it is whether a specific medical treatment is desired, beneficial and proportionate. Accessible communication and supported decision making can reduce instances of disability bias masquerading as caring decision making.

6.4 Risks of Misunderstanding, Coercion, and Social Vulnerability

When living wills are interpreted to be documents that will refuse all care, misconception can occur. When family members pressure elderly or disabled individuals to carry out directives for economic purposes, that is coercion. A social vulnerability can occur if patients accept non-treatment because they feel like a burden. The checks for voluntariness, the possibility of revocation, independent counselling, documented capacity assessment and accessible complaint mechanisms should thus be included.

6.5 Educational Preparedness for Effective Legal Implementation

Educational preparedness refers to the actual state of wants of legality. A right that cannot be invoked, understood or accessed is not a right at all. There should be patient-information sheets and advance care plan templates available in the hospital along with multi-language explanations and referral pathways for palliative care. It is possible to organize awareness programmes with the help of the disability commissioners and district legal services authorities. Professional councils, universities can prepare continuing education content. We want end-of-life autonomy to be part of ordinary civic and health education not something that happens rarely in court.

6.6 Interdisciplinary Training and Public Awareness Models

The content of the interdisciplinary model must include modules on constitutional rights, medical ethics, disability communication, palliative care, grief counselling, documentation, and dispute resolution. Training should be based on cases,

using simulations of people with communication constraints, family conflict, religious considerations, rural locations and low-resource hospitals. Public awareness communication should avoid sensational language to amplify dignity, choice, safeguards and continued care.

7. Recommendations

Following recommendations will enhance the legal reliability clinically workable and disability-inclusive of living wills. Safeguards do not need to be abandoned; they need to be married with education, accessibility and institutional preparation.

7.1 Codification of Passive Euthanasia and Advance Directive Law

It is suggested that a statute should be enacted by parliament which deals with advance medical directives, withdrawal and withholding of life-sustaining treatment, medical board's responsibility, documentation, immunity for good faith professionals and grievance mechanism. A statute will lessen the dependence on judicial clarification in individual cases and provide certainty to hospitals, families and patients. Harish Rana (2026) reinforces the need for codification.

7.2 Standardised Advance Directive Forms in Accessible Formats

Standard forms in plain English, Hindi and regional languages should be made available nationally, along with Braille, large-print, audio, easy-read and digital versions. The forms should elaborate on life-sustaining treatment, artificial nutrition and hydration, ventilation, resuscitation, palliative care, revocation, and appointment of trusted representatives. Accessibility must be a basic function, not an afterthought.

7.3 Awareness Campaigns in Hospitals, Law Colleges, Medical Colleges, and Communities

awareness among the elderly patients should be part of outpatient department, geriatric clinic, palliative care unit, legal aid clinic, disability organization and community health program. Law schools and medical colleges can run living-will clinics under supervision, thereby providing

education to the public and not replacing expert legal advice or consultation with the physician.

7.4 Disability-Inclusive Legal Literacy Modules

Legal literacy modules should explain autonomy, consent, supported decision-making, best interests, and safeguards against coercion. Collaborating help to design materials with disability groups and people with disabilities. We would like to limit paternalism, so that disability will not be a rationale to exclude people from decision-making.

7.5 Training for Medical Boards and Ethics Committees

The medical boards must be trained on Common Cause, the 2023 Amended, Harish Rana, documentation standards, palliative care and disability-inclusive communication. Protocols for urgent consultation, resolution of disagreement and record-keeping should be maintained. Any training conducted should have protection against legal cases for good faith compliance. It should also have provisions against negligent or coercive practice.

7.6 Integration into Special Education, Social Work, Medical Ethics, and Legal Education Curricula

The curricula should incorporate interdisciplinary case studies related to advance care planning, capacity assessment, disability rights and end-of-life counselling. Communication that is well-supported should allow individuals to retain

control over their communication around which they want to form friendships. Family mediation and resource navigation should be included in social work programmes. Legal and medical schools should include coordinated clinical simulations.

7.7 Multilingual Public Information and Outreach

Public information must be multilingual, visually clear and culturally sensitive. The distinction between active and passive euthanasia must be made, which palliative care will continue and that living wills can be revoked. Digital contents must be compliant with accessibility norms. However, the need for offline formats is necessary for rural and low-connectivity contexts.

7.8 Safeguards for Older Persons, Terminally Ill Patients, and Persons with Disabilities

Safeguards should include: independent counselling where coercion is suspected; documentation of communication supports used; involvement of trusted support persons chosen by the patient; and review in cases where family interests conflict with patient preferences. When best-interest decisions are being made for people who do not have present capacity and do not have an advance directive, their prior values should be taken into account, along with medical evidence, the person's dignity, the availability of palliative alternatives and protection from harmful discriminatory assumptions.

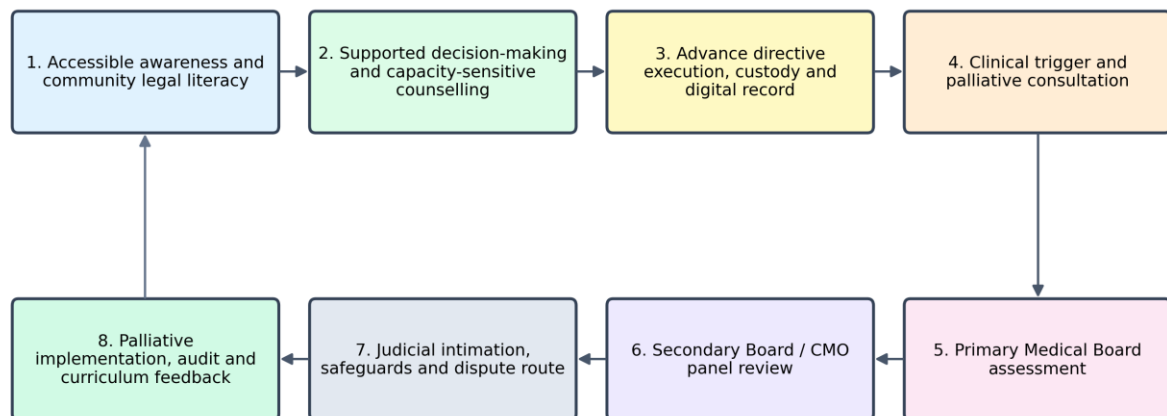


Figure 2. Policy model for disability-inclusive implementation of living wills in India

The proposed policy model begins before illness reaches crisis. It links public awareness, supported decision-making, accessible documentation, medical review, judicial safeguards, palliative implementation and educational feedback. This cyclical design is intended to prevent living wills from becoming one-time legal forms disconnected from professional learning and patient support.

8. Conclusion

India has travelled a significant constitutional distance from ambiguity related to passive euthanasia toward the search and recognition of advance medical directives and dignified end-of-life autonomy. The Common Cause (2018) established the right; the 2023 modification made the procedure more workable; Harish Rana (2026) clarified important questions concerning clinically assisted nutrition and hydration, best-interest reasoning and palliative implementation. These trends show that autonomy at end-of-life is now part of constitutional practice in India.

However, the right is still fragile. The defeat of this can be ignorance, fear, inaccessible language, disability bias, weak institutional protocols, and lack of professional training. As people with disabilities need communication support, accessible information and recognition of legal capacity to gain the autonomy, the problem is sharper. A living will is and not just a document; it

is a bridge between law, medicine, family, education and social trust.

The paper concludes that the legal recognition of end-of-life autonomy in India will not be complete unless it is accompanied by accessibility of education, professional training, disability-inclusive communication and public legal literacy. A humane legal system must protect life, and it also must protect the dignity of person when life is medically sustained without recovery, meaning or consent. The evolution of living wills in India will depend on several factors in addition to courts and statutes, including whether classrooms, hospitals, counselling rooms, legal aid centres and communities are able to understand autonomy at the end of life.

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Data Availability Statement: All materials analysed in this paper are publicly available judicial decisions, statutes, policy documents, guidelines and published academic sources cited in the reference list.

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