INTERNATIONAL JOURNAL FOR LEGAL RESEARCH AND ANALYSIS

Open Access, Refereed Journal Multi Disciplinary
Peer Reviewed

www.ijlra.com

ISSN: 2582-6433

DISCLAIMER

No part of this publication may be reproduced, stored, transmitted, or distributed in any form or by any means, whether electronic, mechanical, photocopying, recording, or otherwise, without prior written permission of the Managing Editor of the *International Journal for Legal Research & Analysis (IJLRA)*.

The views, opinions, interpretations, and conclusions expressed in the articles published in this journal are solely those of the respective authors. They do not necessarily reflect the views of the Editorial Board, Editors, Reviewers, Advisors, or the Publisher of IJLRA.

Although every reasonable effort has been made to ensure the accuracy, authenticity, and proper citation of the content published in this journal, neither the Editorial Board nor IJLRA shall be held liable or responsible, in any manner whatsoever, for any loss, damage, or consequence arising from the use, reliance upon, or interpretation of the information contained in this publication.

The content published herein is intended solely for academic and informational purposes and shall not be construed as legal advice or professional opinion.

ISSN: 2582-6433

ABOUT US

The *International Journal for Legal Research & Analysis (IJLRA)* (ISSN: 2582-6433) is a peer-reviewed, academic, online journal published on a monthly basis. The journal aims to provide a comprehensive and interactive platform for the publication of original and high-quality legal research.

IJLRA publishes Short Articles, Long Articles, Research Papers, Case Comments, Book Reviews, Essays, and interdisciplinary studies in the field of law and allied disciplines. The journal seeks to promote critical analysis and informed discourse on contemporary legal, social, and policy issues.

The primary objective of IJLRA is to enhance academic engagement and scholarly dialogue among law students, researchers, academicians, legal professionals, and members of the Bar and Bench. The journal endeavours to establish itself as a credible and widely cited academic publication through the publication of original, well-researched, and analytically sound contributions.

IJLRA welcomes submissions from all branches of law, provided the work is original, unpublished, and submitted in accordance with the prescribed submission guidelines. All manuscripts are subject to a rigorous peer-review process to ensure academic quality, originality, and relevance.

Through its publications, the *International Journal for Legal Research & Analysis* aspires to contribute meaningfully to legal scholarship and the development of law as an instrument of justice and social progress.

ISSN: 2582-6433

PUBLICATION ETHICS, COPYRIGHT & AUTHOR RESPONSIBILITY STATEMENT

The *International Journal for Legal Research and Analysis (IJLRA)* is committed to upholding the highest standards of publication ethics and academic integrity. All manuscripts submitted to the journal must be original, unpublished, and free from plagiarism, data fabrication, falsification, or any form of unethical research or publication practice. Authors are solely responsible for the accuracy, originality, legality, and ethical compliance of their work and must ensure that all sources are properly cited and that necessary permissions for any third-party copyrighted material have been duly obtained prior to submission. Copyright in all published articles vests with IJLRA, unless otherwise expressly stated, and authors grant the journal the irrevocable right to publish, reproduce, distribute, and archive their work in print and electronic formats. The views and opinions expressed in the articles are those of the authors alone and do not reflect the views of the Editors, Editorial Board, Reviewers, or Publisher. IJLRA shall not be liable for any loss, damage, claim, or legal consequence arising from the use, reliance upon, or interpretation of the content published. By submitting a manuscript, the author(s) agree to fully indemnify and hold harmless the journal, its Editor-in-Chief, Editors, Editorial Board, Reviewers, Advisors, Publisher, and Management against any claims, liabilities, or legal proceedings arising out of plagiarism, copyright infringement, defamation, breach of confidentiality, or violation of third-party rights. The journal reserves the absolute right to reject, withdraw, retract, or remove any manuscript or published article in case of ethical or legal violations, without incurring any liability.

ISSN: 2582-6433

BEYOND THE LIVING WILL: PALLIATIVE CARE AS INDIA'S MISSING HEALTH-LAW INFRASTRUCTURE

AUTHORED BY - DHRUV GANDHI & ANWESH BHOWMICK
National Law Institute University, Bhopal

Abstract

Discussions on end-of-life law in India usually focus on whether life-support treatment may be withheld or withdrawn. That question matters, especially after the Supreme Court's decisions in Common Cause v Union of India. Yet another question comes first, i.e., what care should a patient receive before being asked to choose between further treatment and allowing a natural death? This paper argues for a basic legal guarantee of palliative care. At a minimum, patients with serious illness should receive pain relief, control of other symptoms, clear information, emotional support, proper referral and follow-up at home where needed. India already recognises palliative care in national policy and has eased some rules governing essential pain medicines. However, these steps have not created a clear and enforceable right to care. The paper argues that Article 21 should protect not only a patient's refusal of burdensome treatment but also access to the care needed for a dignified choice. It proposes simple service standards, district-level responsibility, reliable access to medicines, recorded discussions about care preferences and public monitoring of delivery.

Keywords: palliative care; end-of-life care; Article 21; advance directives; opioids; health law; dignity; National Health Policy; serious health-related suffering.

1. Introduction

Indian health-law debates often centre on difficult events such as withdrawal of life support, medical negligence, organ donation, reproductive choice or public-health emergencies. Palliative care receives far less attention, although it affects many patients and families. It includes relief from pain and other troubling symptoms, emotional and social support, and honest conversations about treatment. It may begin at diagnosis and can continue alongside

ISSN: 2582-6433

treatment aimed at curing or controlling disease.[1]

This paper makes a simple argument. India recognises a person's right to make decisions at the end of life, but it has not built a dependable system that makes serious illness or dying less painful. The Supreme Court has treated the right to die with dignity as part of Article 21 and has allowed advance directives and the withholding or withdrawal of life-sustaining treatment under safeguards. [2] In 2023, it simplified parts of that process because the earlier rules were difficult to use. [3] Even so, a choice is hardly free when pain is untreated, symptoms are severe and the family has received no guidance.

This gap is a legal concern. The law explains when treatment may be refused or stopped, but it does not clearly say what comfort and support a hospital must provide. In practice, the right to say no to treatment is clearer than the right to receive relief from suffering.

This paper calls the missing protection a basic palliative-care guarantee. It would not promise the same specialist service in every hospital or give patients a right to treatment that cannot help them. It would ensure a minimum response: assessment and relief of pain and other symptoms; understandable information about the illness and available options; a chance to record care wishes and name a trusted person; access or referral to trained staff; follow-up after discharge; and lawful access to essential pain medicines when clinically required.

The issue belongs to health law, not cyber law. It involves Article 21, medical practice, drug regulation, public funding and the duties of hospitals. The National Health Policy 2017 includes palliative and rehabilitative care within comprehensive primary care and supports care in the community or at home. [4] The National Programme for Palliative Care, or NPPC, also aims to make good-quality pain relief and palliative care available. However, it is funded through the National Health Mission's Mission Flexipool, and the official programme page does not identify a separate budget for it. [5]

The legal issue is therefore not whether palliative care is desirable. It is how a policy aspiration can become a reliable patient entitlement.

[1] World Health Organization, 'Palliative care' (5 August 2020) <https://www.who.int/news-room/fact-sheets/detail/palliative-care> accessed 10 September 2026.
[2] Common Cause (A Regd Society) v Union of India (2018) 5 SCC 1.
[3] Common Cause (A Regd Society) v Union of India (2018) 5 SCC 1.
[4] Ministry of Health and Family Welfare, Government of India, National Health Policy 2017 (2017) 3, 7–9, 13.
[5] National Health Mission, 'National Programme for Palliative Care (NPPC)' https://nhm.gov.in/index1.php?lang=1&level=2&sublinkid=1047&lid=609 accessed 13 September 2026.

ISSN: 2582-6433

2. Dignity in Principle and Support in Practice

The Supreme Court's end-of-life decisions recognise that a person need not undergo unwanted medical treatment simply because it may keep the body alive for longer. In *Common Cause*, the Court held that the right to die with dignity forms part of Article 21. It accepted advance directives and set safeguards for withholding or withdrawing life-sustaining treatment.[6] The judgment did not permit active euthanasia. It dealt with situations in which continued treatment only prolongs dying and no longer reflects the patient's informed wishes.

Common Cause was an important ruling, but it mainly created a process for making decisions. It dealt with mental capacity, living wills, medical boards, family involvement and oversight. Those safeguards protect patients when a decision may be final. Still, the law should not leave families with only two choices, continue aggressive treatment or stop it. Palliative care offers another course: continue caring for the person while actively treating pain, breathlessness, anxiety and other forms of suffering.

These needs often arise well before the final days of life. A person with advanced cancer, heart or lung failure, dementia, motor neurone disease or HIV may need nursing support, pain medicine, help with breathing, counselling and support for caregivers. The need does not end when further intensive treatment is refused. Without palliative care, the patient may be forced to choose between invasive treatment and severe untreated suffering. Such a choice does not reflect dignity.

The Supreme Court itself acknowledged the practical limits of its original procedure. In *Common Cause (A Regd Society) v Union of India* (2023), it noted that "insurmountable obstacles" had arisen in the working of the 2018 directions. The Court permitted an advance directive to be attested by a notary or Gazetted Officer instead of requiring countersignature by a Judicial Magistrate First Class; it also replaced the earlier external board arrangement with primary and secondary medical boards within the hospital process and indicated that each should ordinarily provide its opinion within 48 hours.[7] These revisions improve access to advance directives. But they also demonstrate a broader lesson: rights that exist only through difficult procedures are weak in ordinary clinical settings.

Palliative care presents an even wider practical problem. It is not one treatment that can be ordered on a particular date. It depends on trained staff, medicines, referrals, counselling, records, transport and cooperation between hospitals, local clinics and families. These duties

[6] Common Cause (n 2).
[7] Common Cause (n 3) paras 3, 6 and modifications to paras 198–199 of the 2018 directions.

ISSN: 2582-6433

are spread across Union and state authorities. A court may confirm the validity of a living will, but one judgment cannot ensure that a patient in a remote district receives morphine, nursing support or a home visit.

The distinction between a negative and a positive right helps explain the gap. The State and clinicians cannot insist that all possible treatment must continue regardless of the patient's informed wishes. A palliative-care floor is positive: it requires organisation and provision. It asks the State not simply to respect a choice, but to create conditions in which a choice is informed. Indian constitutional doctrine has long read Article 21 broadly enough to include health-related obligations, especially where deprivation of basic care threatens life and dignity.[8]

3. India's Present Framework

India does not begin from a legal vacuum. The National Health Policy 2017 adopts universal access to good-quality care without financial hardship as its goal. It expressly commits public provision to preventive, promotive, curative, palliative and rehabilitative services; describes patient-centred care as care delivered with dignity and confidentiality; and places palliative care within the comprehensive primary-health-care package to be delivered through Health and Wellness Centres.[9] It also states that frontline workers should provide community or home-based palliative and mental-health services through health-promotion activities, with local-government and village-level support.[10]

This approach is important because palliative care should not be limited to large cancer hospitals. It should begin when a patient needs it and continues across different levels of care. The policy also connects health care with affordability and equal access. When a family must travel repeatedly to a distant city or buy medicines privately because the local hospital has none, that promise of equal care remains unfulfilled.

The NPPC adds an operational dimension. The Ministry of Health and Family Welfare describes palliative care as multidisciplinary care that can be provided in tertiary facilities, community health centres and patients' homes; it includes pain and symptom relief, psychosocial and spiritual support from diagnosis to bereavement. Its stated goal is the availability and accessibility of rational, quality pain relief and palliative care at all levels of health care. The programme proposes state palliative-care cells and district-hospital services

[8] Paschim Banga Khet Mazdoor Samity v State of West Bengal (1996) 4 SCC 37; Consumer Education and Research Centre v Union of India (1995) 3 SCC 42.
[9] Ministry of Health and Family Welfare (n 4) 1–3, 7–9.
[10] ibid 7.

ISSN: 2582-6433

and coordinated action to secure medical access to opioids.[11]

The weakness lies in how the programme is funded and carried out. NPPC support comes through the National Health Mission's flexible funding system, and states must include proposals in their annual plans. This allows states to adapt services to local needs, but it also means that palliative care may lose out to other priorities. A programme that depends on yearly proposals is not the same as a service that every eligible patient can expect.

Access to pain medicine is another part of the problem. Earlier rules under the Narcotic Drugs and Psychotropic Substances Act 1985 required several state-level licences, making it difficult for hospitals to obtain and dispense morphine and similar medicines. The 2014 amendment created the category of an 'essential narcotic drug' and allowed central rules for medical and scientific use. [12] The change was meant to reduce the licensing burden on recognised medical institutions.

Changing the statute, however, does not put medicine in a patient's hands. Access still depends on whether a hospital has the required recognition, keeps the medicine in stock and has doctors who are trained and willing to prescribe it. Rules must prevent diversion, but they should not frighten hospitals away from lawful medical use. A balanced system needs simple authorisation, secure storage, proper records, regular supply, clinical guidance and training.

Good palliative care also depends on conversation. A living will alone cannot explain everything that matters to a patient. Doctors should ask what the patient understands, what outcomes the patient fears, which treatments may help, and whom the patient wants involved. Families often provide essential support in India, but they should not override a capable patient's wishes. If the patient lacks capacity, decisions should reflect earlier wishes and best interests. The 2023 Common Cause order keeps safeguards for this process.[13]

India therefore has many of the necessary parts: Article 21, a right to refuse burdensome treatment, a national policy, the NPPC and improved rules for essential opioids. The missing part is a clear legal duty that joins these measures together and makes public authorities answerable for delivery.

4. From Policy Commitment to a Minimum Entitlement

The proposed guarantee should set a basic level of palliative care that is available, reachable, respectful and safe. It should apply whenever a clinician finds serious suffering caused by a

[11] National Health Mission (n 5).
[12] Narcotic Drugs and Psychotropic Substances (Amendment) Act 2014, ss 2(viiia), 9(1)(a).
[13] Common Cause (n 3), modifications to paras 198.4.1–198.4.7.

ISSN: 2582-6433

life-threatening, progressive or advanced long-term illness. Need should be the test, not the name of the disease. A rule limited to cancer or the last few days of life would exclude many people with heart, lung, kidney or neurological disease, dementia and frailty.

4.1 What Every Patient Should Be Able to Expect

Every district hospital and named referral centre should assess a referred patient within a fixed period. The assessment should cover pain, breathing problems, nausea, anxiety, low mood, daily functioning, pressure on caregivers and financial or social difficulties. It should lead to a written care plan that is explained in a language the patient and family can understand.

Primary-care centres should offer basic symptom care and follow a clear referral route. The National Health Policy already supports broad primary care and services at home.[14] A patient who is too ill to travel should not lose access altogether. Depending on local resources, states could arrange home visits, telephone follow-up, community health workers or partnerships with non-profit services. Each district should publish one clear contact point for help.

Thirdly, essential palliative medicines should be included in facility procurement and stock-monitoring systems. Where opioids are clinically indicated, a recognised medical institution should be able to provide them or promptly refer the patient to a named facility that can. The legal duty should be one of reasonable availability and continuity, not an unrealistic promise that every small centre stock every controlled medicine. Stock-out data, referral delays and geographic access should be reported publicly in aggregated form.

Hospitals treating serious illness should keep a short record of the patient's goals of care. This is different from a formal advance directive. It records what the patient knows, which outcomes matter, who should join discussions, and whether intensive care or resuscitation has been considered. Staff should review it as the illness changes. A clear record can prevent rushed decisions and help different doctors follow the same plan.

The guarantee must also guard against discrimination. Palliative care must never become an excuse to deny useful treatment to someone because that person is poor, old, disabled or seriously ill. It may be given alongside treatment for the underlying disease. Its purpose is to ease suffering and support choice, not to cut costs by quietly withholding care.

4.2 Making Informed Choice Possible

A basic guarantee would make patient choice more meaningful. Pain relief can help a person

[14] Ministry of Health and Family Welfare (n 4) 7–9.

ISSN: 2582-6433

think and speak clearly. Honest information can reduce fear. Counselling can help a family understand that stopping treatment which no longer helps is not the same as abandoning the patient. Access to a palliative-care team also gives the doctor a humane alternative to repeated and burdensome treatment.

Consider a patient with advanced heart failure who repeatedly reaches an emergency department with breathlessness. Without a palliative-care pathway, the patient may undergo recurring admissions, invasive procedures and distressing transfers, while the family makes decisions in crisis. With the floor in place, the patient receives symptom assessment, realistic information, a documented caregiver contact, access to medicines and a referral link for home follow-up. If later the patient refuses further invasive treatment, that decision is more plausibly informed and dignified. The legal value of the living will is strengthened by the practical availability of care.

4.3 Locating Duty Within Article 21

Article 21 does not require judges to run hospitals, and a constitutional right should not become a rigid medical checklist. It can, however, require the State to act reasonably, fairly and with respect for dignity. The government has already accepted through its policy and programme that palliative care is part of health care. A basic legal guarantee would give practical meaning to that commitment.

Courts should review the government's system rather than decide individual drug doses or staffing patterns. They can ask whether the State has published minimum standards, named responsible facilities, created referral routes and reported gaps in medicines and staff. They can also examine whether some districts or groups are repeatedly left out. This keeps clinical choices with doctors while still making public administration answerable.

5. Implementing the Right to Palliative Care

A national law on end-of-life and palliative care would provide the clearest foundation. India need not wait for a new Act, however. Central standards, state plans, programme funding and hospital rules can begin to create the guarantee now.

The Union Ministry of Health and Family Welfare should first issue simple minimum standards under the National Health Policy and the NPPC. These should define who qualifies for palliative care, when referral is required, which medicines must be available, what training staff need and how patients may complain. The standards should cover cancer as well as heart, lung, kidney and neurological disease, HIV, old age, childhood illness and disability-related

ISSN: 2582-6433

conditions.

Each state should then publish a plan for every district. The plan should name the officer responsible, list facilities offering outpatient, inpatient and home-linked care, explain referral and transport arrangements, identify institutions allowed to dispense essential narcotic drugs and provide a complaint route. It should also show how patients in remote or underserved areas will be reached.

Hospital licensing and quality rules should include basic palliative-care duties. Hospitals treating cancer, organ failure, neurological disease or other major chronic conditions should record care discussions and maintain a working referral arrangement. Large hospitals should have multidisciplinary teams. A smaller hospital should be able to meet its duty through prompt referral and follow-up rather than being required to create a specialist unit.

Drug-control and health authorities should work together. They should maintain a simple public list showing which institutions are authorised, where medicines are available and whether trained staff are present. Patient details need not appear. The aim is to see whether the 2014 reform has improved access outside major cities. Since the NPPC already calls for coordination between health and revenue authorities, district officials could review availability each month.[15]

Hospitals should also make advance-care planning a normal and voluntary service. Under the 2023 Supreme Court procedure, an adult may sign an advance directive before two witnesses and have it attested by a notary or Gazetted Officer. [16] Hospitals could offer counselling and a short form in plain language. No one should be pressured to sign it, and it should never become a condition for admission, insurance or treatment.

One concern is that the public health system cannot afford another general promise. The guarantee proposed here is deliberately modest. It does not require every village clinic to copy a large hospital. It requires basic assessment, a known referral route, necessary medicines and continued contact. Much of this can be added to existing primary, geriatric and home-based care. Leaving suffering untreated also carries costs through repeated emergency visits, avoidable admissions and heavy family spending.

6. Practical Concerns and Necessary Safeguards

One objection is that India's public health system cannot undertake another universal guarantee. This objection identifies a real resource constraint, but it misunderstands the

[15] National Health Mission (n 5).
[16] Common Cause (n 3), modifications to paras 198.3.1–198.3.6.

ISSN: 2582-6433

proposal. A palliative-care floor does not require every village facility to replicate a tertiary hospital. It requires a defined local pathway, basic assessment, referral, essential medicines and continuity. Much of this can be integrated into existing primary care, non-communicable disease, geriatric and home-based services. The cost of doing nothing is also substantial: repeated emergency visits, inappropriate admissions, catastrophic expenditure and avoidable suffering.

A second objection is that a legal guarantee will lead to medical litigation and defensive practice. Clear standards can reduce rather than increase uncertainty. Clinicians are more vulnerable when there is no documented discussion, no referral option and no institutional protocol. A statutory safe harbour should protect clinicians and facilities that act in good faith, follow recognised standards, document patient preferences and refer appropriately. Negligence law should not demand impossible outcomes; it should ask whether reasonable palliative assessment and communication occurred.

A third objection concerns opioids and diversion. The answer is not to preserve barriers that deny pain relief. The NDPS Act itself recognises medical and scientific use, and the 2014 framework was intended to make access more workable.[17] A balanced regime can combine recognised-medical-institution authorisation, secure storage, prescription records, periodic audit and clinician training. Public-health goals and controlled-substance safeguards should reinforce each other.

A fourth objection is cultural: families, not individuals, often make health decisions. Indian law should respect family care while retaining the patient as the primary rights-holder. The goals-of-care process should invite family participation with the patient's permission. Where capacity is absent, decisions should reflect the patient's known wishes, values and best interests, not the financial convenience or social preference of others. The *Common Cause* safeguards provide a useful starting point, but care planning should begin earlier than the moment of treatment withdrawal.

7. Conclusion

Debate about end-of-life law should not stop at whether a ventilator may be withdrawn. That question sets an important limit on medical and state power, but dignity requires more than freedom from unwanted treatment. A seriously ill person also needs relief from pain, clear information, support for the family, access to medicines and care that continues after leaving

[17] Narcotic Drugs and Psychotropic Substances (Amendment) Act 2014 (n 13).

ISSN: 2582-6433

hospital.

A basic palliative-care guarantee would connect legal choice with practical support. It would not force treatment, replace curative medicine or permit treatment to be stopped without consent. It would require published standards, clear district responsibility, access to medicines, recorded care discussions, follow-up at home where appropriate and open reporting of gaps. These are practical steps, not another broad constitutional slogan. Palliative care should therefore be seen as part of end-of-life law, not as an optional extra.