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Judicial Recognition of Passive Euthanasia in India: A Critical Analysis of Supreme Court Jurisprudence and the Right to Die with Dignity

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ABSTRACT

The question of whether an individual possesses a constitutionally enforceable right to die with dignity has emerged as one of the most intellectually demanding and morally intricate questions confronting Indian constitutional jurisprudence in the contemporary era. Situated at the confluence of fundamental rights, biomedical ethics, and evolving human rights norms, the judicial treatment of passive euthanasia in India reflects a gradual yet decisive normative shift from near absolute prohibition to qualified constitutional recognition under Article 21 of the Constitution of India.

This paper undertakes a rigorous critical examination of the judicial architecture governing end-of-life decision-making in India, tracing its doctrinal evolution through a sequence of watershed Supreme Court pronouncements. The analysis proceeds through four critical stages: the foundational recognition of passive euthanasia as legally permissible in Aruna Ramachandra Shanbaug v. Union of India ; its constitutional elevation and the validation of Advance Medical Directives in Common Cause v. Union of India ; the procedural liberalization introduced through the Supreme Court's 2023 modifications ; and the operational crystallization achieved in Harish Rana v. Union of India (2026) , which meaningfully extended the definition of medical treatment to encompass Clinically Assisted Nutrition and Hydration.

Adopting a doctrinal legal methodology, the paper draws upon primary judicial sources, Law Commission of India Reports , and comparative international legal frameworks to assess the efficacy and shortcomings of the prevailing regime. The central findings reveal a persistent implementation deficit despite the Common Cause judgment's robust theoretical affirmation of patient autonomy; the original procedural safeguards imposed excessive institutional burdens, fostering physician reluctance and contributing to a discernible rise in terminal discharges against medical advice. While the subsequent judicial interventions have alleviated some of these structural impediments, considerable ambiguities persist with

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respect to digital registry infrastructure, the capacity of rural healthcare institutions, and the resolution of intra-family disputes over end of life choices.

The paper concludes that although the Supreme Court has constructed a constitutionally sound and progressively sensitive foundation for the recognition of passive euthanasia, the continued absence of comprehensive parliamentary legislation constitutes a critical lacuna that frustrates the meaningful realisation of this right in practice. Immediate legislative intervention is warranted to establish uniform, culturally attuned, and technologically integrated end-of-life care protocols that translate judicial intent into accessible, ground-level reality.

Keywords: *Passive Euthanasia, Right to Die with Dignity, Article 21, Advance Medical Directives, Living Will, Common Cause, Aruna Shanbaug, End of Life Care, Supreme Court of India, Legislative Gap*

I. INTRODUCTION

The philosophical and legal discourse surrounding euthanasia finds its etymological roots in the ancient Greek words *eu*, meaning "good," and *thanatos*, meaning “death", together signifying a peaceful or dignified departure from life. The term was first formally employed in the seventeenth century by the English philosopher Sir Francis Bacon, who envisioned the physician's role as extending beyond mere curative intervention to encompass the humane easing of a patient's final passage.[2] Since that early articulation, the concept has traversed centuries of intense ethical, theological, and jurisprudential contestation, ultimately crystallising into one of the most consequential debates in contemporary medical law the fundamental tension between the state's compelling interest in the preservation and sanctity of human life, and the individual's equally compelling claim to personal autonomy, bodily integrity, and the right to determine the circumstances of one's own death.[3]

Within modern medico-legal discourse, euthanasia is conventionally bifurcated into two analytically distinct categories. Active euthanasia denotes a deliberate, affirmative act such as the administration of a lethal pharmacological agent undertaken by a medical practitioner with the specific intention of causing the immediate death of a patient in order to relieve intractable suffering.[4] Passive euthanasia, by contrast increasingly characterised in contemporary judicial language as the withholding or withdrawal of life-sustaining medical treatment and involves the

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[2] FRANCIS BACON, THE ADVANCEMENT OF LEARNING 101 (1605); *see also* Suresh Bada Math & Santosh K. Chaturvedi, *Euthanasia: Right to Life vs. Right to Die*, 53 INDIAN J. MED. RES. 899, 899 (2012).

[3] *See generally* JOHN KEOWN, EUTHANASIA, ETHICS AND PUBLIC POLICY: AN ARGUMENT AGAINST LEGALISATION 3–15 (2d ed. 2018).

[4] Aruna Ramachandra Shanbaug v. Union of India, (2011) 4 SCC 454, ¶ 20 (India).

deliberate omission of therapeutic interventions that serve only to artificially extend the biological existence of a terminally ill patient or one residing in a persistent vegetative state, without any corresponding prospect of recovery or restoration of meaningful human function.[5]

The global legal response to these two categories diverges markedly, shaped by deeply embedded cultural, religious, and philosophical traditions. Progressive jurisdictions, including the Netherlands, Belgium, and Canada, have enacted legislative frameworks that permit physician-assisted dying or active euthanasia under carefully delineated procedural safeguards, reflecting a normative prioritisation of individual autonomy in end-of-life decision-making.[6] India, historically, has occupied the opposite end of this spectrum. Anchored in socio-cultural traditions that vest profound sanctity in human life and reinforced by a constitutional framework that imposes an affirmative state duty to protect life, Indian penal law has maintained an unambiguous prohibition on active euthanasia and physician-assisted suicide, classifying them as culpable homicide or abetment to suicide under the Indian Penal Code, 1860.[7]

Yet this seemingly settled legal landscape has been subjected to mounting pressure by the relentless advancement of medical technology. Modern intensive care infrastructure now possesses the capacity to sustain biological function indefinitely long after the irreversible cessation of cognitive capacity and any prospect of conscious, meaningful existence.[8] This technological reality confronted Indian constitutional jurisprudence with a profound normative challenge that statutory law had neither anticipated nor addressed: whether the prolongation of biological life through artificial means, in the absence of patient consent and in the face of irreversible medical deterioration, is consistent with the dignity that Article 21 of the Constitution of India guarantees to every person.[9]

It is against this complex backdrop that the present paper situates its inquiry. The central research questions animating this analysis are fourfold. First, does the fundamental right to life under Article 21 inherently subsume within it a constitutionally cognisable right to die with dignity? Second, by what doctrinal reasoning did the Supreme Court of India traverse the distance from treating the right to die as a penal offence to recognising it as a protected constitutional liberty? Third, to what degree do the procedural guidelines, as liberalised by the

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[5] Common Cause v. Union of India, (2018) 5 SCC 1, ¶ 30 (India).

[6] Termination of Life on Request and Assisted Suicide Act 2002 (Neth.); Act on Euthanasia 2002 (Belg.); Criminal Code, RSC 1985, c C-46, § 241.2 (Can.), *as amended by* An Act to Amend the Criminal Code and to Make Related Amendments to Other Acts (Medical Assistance in Dying), SC 2016, c 3.

[7] Indian Penal Code, 1860, §§ 299, 304, 306 (India).

[8] Vikram Patel et al., *Persistent Vegetative State and the Law in India*, 6 INDIAN J. CRITICAL CARE MED. 201, 202 (2014).

[9] INDIA CONST. art. 21; *see also* Francis Coralie Mullin v. Union Territory of Delhi, (1981) 1 SCC 608, ¶ 8 (India) (holding that Article 21 encompasses the right to live with human dignity).

Supreme Court's 2023 modifications[10] and operationally affirmed in *Harish Rana v. Union of India* (2026)[11], succeed in reconciling the competing imperatives of safeguarding against misuse and facilitating genuinely compassionate end-of-life care? Finally, how does India's judicially constructed framework measure against the legislative models operative in comparable jurisdictions, and what parliamentary interventions remain indispensable to address the persistent implementation deficits that continue to frustrate the practical realisation of this right?

Through a rigorous doctrinal analysis of primary judicial texts, Law Commission reports, and comparative statutory material, this paper endeavours to provide a comprehensive and critically nuanced assessment of where Indian law stands and where it must yet go in its ongoing engagement with the right to die with dignity.

II. EVOLUTION OF EUTHANASIA JURISPRUDENCE IN INDIA

The doctrinal evolution of euthanasia jurisprudence in India constitutes a compelling illustration of constitutional law's capacity for adaptive reinterpretation in response to shifting moral, medical, and social realities. The trajectory of this evolution is not linear but dialectical, marked by bold judicial assertions, decisive reversals, incremental statutory deliberation, and ultimately, transformative constitutional recognition. To fully appreciate the normative architecture that governs end-of-life decisions in India today, it is necessary to trace this progression methodically from its foundational origins.

A. The Early Jurisprudential Landscape: Prohibition and Its First Challenge

Prior to 2011, the legal status of the right to die in India was almost entirely refracted through the prism of suicide law, and specifically through the criminalisation of attempted suicide under Section 309 of the Indian Penal Code, 1860.[12] The first significant judicial challenge to this framework arose in *P. Rathinam v. Union of India* (1994), where a Division Bench of the Supreme Court was called upon to assess the constitutional validity of penalising a person who had attempted to end their own life.[13] Drawing upon a structural interpretive analogy with other enumerated fundamental rights, the Court reasoned that just as Article 19(1)(a) implicitly encompasses the right to remain silent alongside the right to speak, the right to life guaranteed

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[10] Common Cause v. Union of India, W.P. (C) No. 215/2005, Order dated January 24, 2023 (Supreme Court of India).

[11] Harish Rana v. Union of India, (2026) (Supreme Court of India).

[12] Indian Penal Code, 1860, § 309 (India).

[13] P. Rathinam v. Union of India, (1994) 3 SCC 394 (India).

under Article 21 must correspondingly be understood to include within its ambit the right not to live effectively, rendering Section 309 constitutionally infirm.[14]

This expansive and, at the time, radical reading of Article 21 was, however, short-lived. Two years later, in *Gian Kaur v. State of Punjab* (1996), a five-judge Constitution Bench of the Supreme Court decisively overruled *P. Rathinam* and authoritatively repudiated the notion of a constitutional right to die.[15] The Court in *Gian Kaur* reasoned with considerable force that the right to life enshrined in Article 21 is an inherently natural right, one that protects, nurtures, and affirms existence, whereas suicide represents an unnatural and self-destructive negation of that very existence. On this reasoning, a "right to die" was held to be fundamentally irreconcilable with, and indeed antithetical to, the "right to life."[16]

Yet *Gian Kaur* was not without its nuances. While the Constitution Bench firmly closed the door on any generalised right to die, it simultaneously and significantly distinguished between the act of suicide and the entitlement of a person in the terminal stages of illness to experience a natural death with dignity, free from the artificial prolongation of suffering through technological intervention.[17] This careful judicial distinction preserved a constitutionally significant aperture through which future jurisprudence would eventually pass.

B. Legislative Deliberation: The Law Commission Reports

In the aftermath of *Gian Kaur*, the Law Commission of India undertook a structured legislative inquiry into the normative and practical dimensions of end-of-life care. The 196th Report of 2006, titled *Medical Treatment to Terminally Ill Patients (Protection of Patients and Medical Practitioners)*, drew a principled and consequential distinction between active euthanasia, which the Commission unequivocally characterised as unlawful and the withholding or withdrawal of life-sustaining treatment from a patient for whom such treatment had ceased to serve any therapeutic purpose.[18] The Report concluded that a physician who refrains from administering futile treatment, acting in the patient's best interest and in accordance with sound medical judgment, does not thereby incur criminal liability for culpable homicide.[19] This conclusion provided an indispensable medico-legal foundation upon which subsequent judicial reasoning would build.

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[14] *Id.* at ¶ 26; *see also* INDIA CONST. art. 19(1)(a); INDIA CONST. art. 21.

[15] Gian Kaur v. State of Punjab, (1996) 2 SCC 648 (India).

[16] *Id.* at ¶ 22.

[17] *Id.* at ¶ 24 (observing that the right to live with dignity may, in its terminal application, encompass the right to die naturally and without prolonged suffering).

[18] LAW COMMISSION OF INDIA, REPORT NO. 196: MEDICAL TREATMENT TO TERMINALLY ILL PATIENTS (PROTECTION OF PATIENTS AND MEDICAL PRACTITIONERS) 12–14 (2006).

[19] *Id.* at 18–19.

Nevertheless, the 196th Report adopted a notably cautious stance regarding Advance Medical Directives. Expressing concern about the potential for exploitation in a society where robust social security mechanisms remain underdeveloped and familial motivations can be complex, the Commission explicitly declined to recommend the legalisation of living wills, apprehending that such instruments might be susceptible to misuse by interested parties acting from ulterior motives.[20]

C. The Aruna Shanbaug Case: A Landmark of Tragedy and Legal Transformation

The theoretical and legislative deliberations of the preceding years were thrust into urgent, human focus by the extraordinary facts of *Aruna Ramachandra Shanbaug v. Union of India* (2011), a case that would fundamentally and irreversibly alter the landscape of euthanasia law in India.[21] Aruna Shanbaug, a nurse employed at KEM Hospital in Mumbai, had been the victim of a savage sexual assault in 1973 that inflicted catastrophic brain damage, confining her to a permanent vegetative state from which she would never recover.[22] For thirty-six years, she was sustained by artificial feeding, her biological existence maintained through the dedicated care of the hospital staff who attended to her throughout that prolonged ordeal.[23]

A public interest litigation filed before the Supreme Court by a journalist and activist, purporting to act as Shanbaug's "next friend," sought judicial authorisation for the withdrawal of life support.[24] The Supreme Court, while ultimately declining to grant the relief sought, holding that the hospital staff, who had cared for Shanbaug with unwavering devotion over decades, were more appropriately regarded as her true next friend and were opposed to the withdrawal, nonetheless seized the occasion to make a pronouncement of historic constitutional significance.[25] For the first time in Indian legal history, the Supreme Court unequivocally recognised passive euthanasia as legally permissible, drawing a firm and principled distinction between the impermissible act of actively causing a patient's death and the legally cognisable withholding or withdrawal of life-sustaining treatment.[26]

To guard against the risk of abuse, the Court constructed a procedural framework grounded in the doctrine of *parens patriae*, requiring that any decision to withdraw life support from a patient incapable of expressing autonomous consent be subjected to prior approval by the

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[20] *Id.* at 25–26.
[21] Aruna Ramachandra Shanbaug v. Union of India, (2011) 4 SCC 454 (India).
[22] *Id.* at ¶ 3.
[23] *Id.* at ¶ 5.
[24] *Id.* at ¶ 7.
[25] *Id.* at ¶ 89.
[26] *Id.* at ¶ 100.

relevant State High Court, following a structured assessment by a duly constituted medical board.[27] While this framework reflected sound constitutional instincts regarding the protection of vulnerable individuals, its practical operation proved deeply problematic. The requirement of High Court approval was, by any measure, onerous, protracted, and financially prohibitive, generating a pronounced chilling effect upon the medical community and effectively placing the humane relief of passive euthanasia beyond the reach of the overwhelming majority of patients and families in India.[28]

The 241st Law Commission Report of 2012 revisited these developments, reaffirming both the legal permissibility of passive euthanasia and the necessity of robust judicial oversight to guard against malicious intent, while persisting in its reluctance to recognise the validity of living wills.[29] The cumulative effect of the *Aruna Shanbaug* guidelines was, paradoxically, to render the very right they had ostensibly recognised largely inaccessible in practice, a tension that would remain unresolved until the transformative intervention of the *Common Cause* litigation, which forms the subject of the subsequent section.

III. CONSTITUTIONAL FRAMEWORK

The judicial recognition of passive euthanasia in India cannot be understood in isolation from the broader constitutional canvas upon which it is painted. At its normative core, the entire edifice of end-of-life jurisprudence in India rests upon the progressive and expansive interpretation of Article 21 of the Constitution of India, which provides that no person shall be deprived of their life or personal liberty except in accordance with a procedure established by law.[30] While the text of Article 21 is deceptively brief, decades of purposive constitutional adjudication have invested it with a breadth and depth that extend far beyond the mere protection of physical or biological existence.

A. Article 21 and the Right to Live with Dignity

The Supreme Court's interpretive journey with Article 21 began in earnest with *Francis Coralie Mullin v. Union Territory of Delhi* (1981), where the Court held that the right to life cannot be confined to its most reductive, animalistic dimension, the bare fact of being alive, but must be understood to encompass the right to live with basic human dignity.[31] This foundational proposition was progressively elaborated in subsequent decisions, with the Court consistently

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[27] *Id.* at ¶ 101–103.

[28] *See* Common Cause v. Union of India, (2018) 5 SCC 1, ¶ 17 (India) (acknowledging the practical inaccessibility created by the *Aruna Shanbaug* procedural framework).

[29] LAW COMMISSION OF INDIA, REPORT NO. 241: PASSIVE EUTHANASIA A RELOOK 8–11 (2012).

[30] INDIA CONST. art. 21.

[31] Francis Coralie Mullin v. Union Territory of Delhi, (1981) 1 SCC 608, ¶ 8 (India).

affirming that Article 21 protects not merely survival but the quality and dignity of that survival.[32]

Transposed into the domain of end-of-life decision-making, this interpretive tradition carries profound implications. Where a patient's biological existence is sustained entirely through technological intervention, in the complete absence of cognitive function, meaningful human interaction, or any medically credible prospect of recovery, the mere continuation of that existence cannot, by any principled constitutional reasoning, be equated with a life of dignity.[33] The Supreme Court, in confronting this reality, was compelled to recognise that in such circumstances, the constitutional guarantee of dignity operates not as an argument for the preservation of life at any cost, but rather as a protection against the indignity of an artificially prolonged, painful, and purposeless biological existence.[34]

B. Autonomy, Bodily Integrity, and the Right to Refuse Treatment

The constitutional framework governing passive euthanasia draws further and decisive support from the doctrine of personal autonomy and bodily integrity. The normative foundation for this dimension of the analysis was substantially reinforced by the Supreme Court's landmark nine-judge decision in *K.S. Puttaswamy v. Union of India* (2017), which unequivocally established the right to privacy encompassing within it the right to bodily autonomy and personal self-determination as a fundamental, inalienable right guaranteed under Part III of the Constitution.[35]

The implications of *Puttaswamy* for end-of-life jurisprudence are far-reaching. If an individual possesses a constitutionally protected right to make autonomous decisions concerning their own body, it follows necessarily and logically that a competent adult retains the absolute entitlement to refuse medical treatment, including life-sustaining treatment, irrespective of the medical establishment's assessment of what might be in that person's best clinical interest.[36] To compel a competent patient to submit to invasive, unwanted, and medically futile treatment against their expressed will is not merely a clinical misjudgement; it constitutes an egregious violation of their bodily integrity and an impermissible deprivation of personal liberty within the meaning of Article 21.[37] Understood in this light, the right to die with dignity is not, and must not be, construed as an affirmative right to actively terminate one's life. It is, rather, a negative liberty,

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[32] Bandhua Mukti Morcha v. Union of India, (1984) 3 SCC 161, ¶ 10 (India); *see also* Unni Krishnan v. State of Andhra Pradesh, (1993) 1 SCC 645, ¶ 83 (India).

[33] Common Cause v. Union of India, (2018) 5 SCC 1, ¶ 198 (India).

[34] *Id.* at ¶ 202.

[35] K.S. Puttaswamy v. Union of India, (2017) 10 SCC 1, ¶ 309–310 (India).

[36] *Id.* at ¶ 312; *see also* Common Cause v. Union of India, (2018) 5 SCC 1, ¶ 223 (India).

[37] Common Cause v. Union of India, (2018) 5 SCC 1, ¶ 225 (India).

the right to be free from unwarranted, non-consensual intrusion by the state or the medical establishment into the natural process of dying.[38]

C. Incompetent Patients: Substituted Judgment and Best Interests

The constitutional analysis becomes considerably more intricate when the patient in question lacks the cognitive capacity to exercise autonomous decision-making, as is the case with individuals in a persistent vegetative state or those rendered permanently unconscious through illness or injury. In such circumstances, the framework of explicit personal autonomy yields to two complementary doctrines that together govern the constitutional protection of the incapacitated patient.

The first is the doctrine of **substituted judgment**, which requires that authorised decision-makers whether family members, duly constituted medical boards, or courts exercising *parens patriae* jurisdiction endeavour to place themselves, as faithfully as possible, in the position of the incapacitated individual and to determine what that person would, in all likelihood, have chosen for themselves had they retained the capacity to do so.[39] This doctrine seeks to honour the patient's subjective autonomy even in the absence of its present exercise.

The second and complementary principle is that of the **best interests** of the patient, which operates as a safeguard where the substituted judgment inquiry yields no clear answer. Under this standard, decision-makers are required to assess, objectively and dispassionately, whether the continuation of life-sustaining treatment serves any therapeutic purpose proportionate to the burdens it imposes upon the patient, or whether it merely perpetuates suffering without clinical or humane justification.[40]

Where a patient remains entirely dependent upon clinically assisted life support with no medically credible prospect of recovery, the state's traditional and legitimate interest in the preservation of life does not disappear, but it is, in such extreme circumstances, constitutionally outweighed by the equally compelling imperative to protect the individual from the profound indignity of an artificially prolonged and agonising death.[41] The Supreme Court has unequivocally affirmed that in these circumstances, the authorised withdrawal of futile life-sustaining treatment by a medical practitioner is not merely legally permissible, it is entirely

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[38] *Id.* at ¶ 229.

[39] Aruna Ramachandra Shanbaug v. Union of India, (2011) 4 SCC 454, ¶ 94 (India).

[40] Common Cause v. Union of India, (2018) 5 SCC 1, ¶ 247 (India).

[41] *Id.* at ¶ 251.

consistent with both the practitioner's duty of care and the constitutional guarantee of human dignity that Article 21 enshrines.[42]

Together, these constitutional principles, the dignitarian interpretation of Article 21, the right to autonomous refusal of treatment grounded in *Puttaswamy*, and the protective doctrines of substituted judgment and best interests form the normative bedrock upon which the Supreme Court's landmark pronouncements in *Aruna Shanbaug* and *Common Cause* were constructed, and upon which any future legislative framework must necessarily be built.

IV. ANALYSIS OF THE COMMON CAUSE JUDGMENT (2018)

The accumulated weight of the procedural deficiencies inherent in the *Aruna Shanbaug* framework and the near-complete inaccessibility of passive euthanasia that those deficiencies generated in practice eventually rendered a fresh and more comprehensive judicial intervention not merely desirable but constitutionally imperative. That intervention arrived in the form of *Common Cause (A Regd. Society) v. Union of India* (2018), a judgment that stands as the most transformative pronouncement in the history of Indian end-of-life jurisprudence.[143]

A. Background and Constitutional Challenge

The litigation originated as a Public Interest Petition filed in 2005 by a registered non-governmental organisation, advancing the argument that terminally ill patients possess an inherent constitutional entitlement to refuse life-prolonging medical treatment and seeking formal judicial recognition of the legal validity of Advance Medical Directives.[244] The petition thus framed two interrelated constitutional questions of the first order: whether the right to die with dignity constitutes a fundamental right under Article 21, and whether an individual's prospective refusal of medical treatment, expressed through a living will, merits legal enforceability.

A five-judge Constitution Bench, presided over by Chief Justice Dipak Misra, delivered a unanimous verdict, albeit one expressed through multiple concurring opinions that decisively and comprehensively resolved both questions in the affirmative, fundamentally reconfiguring the normative landscape of medical law and bioethics in India.[45]

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[42] *Id.* at ¶ 263.

[43] Common Cause v. Union of India, (2018) 5 SCC 1 (India).

[44] *Id.* at ¶ 5–7.

[45] *Id.* at ¶ 1 (noting the Constitution Bench composition and the unanimous operative conclusion).

B. Core Constitutional Pronouncements

The most significant doctrinal contribution of the *Common Cause* judgment was its unequivocal declaration that the right to die with dignity constitutes a fundamental right within the protective scope of Article 21 of the Constitution.[46] In so holding, the Constitution Bench formally and irrevocably equated the constitutional value of a dignified death with that of a dignified life, a proposition that carries profound implications not merely for medical law but for the broader jurisprudence of human dignity in India.

Equally significant was the Court's reversal of the cautious, restrictive posture that had characterised the Law Commission's earlier deliberations on the subject. Departing from the Commission's persistent reluctance to recognise living wills, the Supreme Court afforded full legal validity to Advance Medical Directives, holding that a competent adult of sound mind possesses an unassailable right to execute such a directive prospectively specifying the medical treatments they wish to refuse should they subsequently lose the capacity to make autonomous decisions.[47] In doing so, the Court gave meaningful constitutional content to the principle of patient autonomy, ensuring that an individual's right to self-determination would survive the very cognitive incapacity that makes end-of-life decisions most consequential.

The judgment also provided long-overdue clarity on a question that had generated persistent legal uncertainty since *Gian Kaur,* namely, whether a patient's refusal of life-sustaining treatment amounts to the unnatural act of suicide. The Court answered this question with unambiguous firmness: the exercise of a patient's right to refuse futile or burdensome medical treatment is a constitutionally protected act of personal autonomy, fundamentally distinct in its nature and intent from the act of suicide, and accordingly does not attract the penal provisions of Section 309 of the Indian Penal Code, 1860.[48] This clarification was essential to insulating both patients asserting this right and the medical practitioners who honour it from unjustified criminal exposure.

C. The Procedural Framework and Its Structural Limitations

While the doctrinal victory secured by the *Common Cause* judgment for the cause of patient autonomy was unqualified, the Court remained acutely conscious of the very real risks of coercion, undue influence, and exploitation that attend end-of-life decisions in a country characterised by uneven medical literacy, acute socio-economic vulnerability, and significant

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[46] *Id.* at ¶ 198.

[47] *Id.* at ¶ 223–225.

[48] *Id.* at ¶ 229; *see also* Indian Penal Code, 1860, § 309 (India); Gian Kaur v. State of Punjab, (1996) 2 SCC 648, ¶ 22 (India).

resource disparities across its healthcare infrastructure.[49] These legitimate concerns manifested in the construction of an elaborate, multi-tiered procedural framework intended to safeguard the integrity of both the execution of Advance Medical Directives and the subsequent decision to withdraw life-sustaining treatment.

For the valid execution of an Advance Medical Directive, the Court mandated that the document be signed voluntarily by the executant in the presence of two independent witnesses and thereafter subjected to meticulous scrutiny and countersignature by a Judicial Magistrate of the First Class.[50] The involvement of a judicial officer at the execution stage was intended to serve as an institutional guarantee against the possibility of a document being fabricated, coerced, or procured by interested parties.

The procedural requirements governing the actual withdrawal of life support were equally elaborate, and applied whether or not a valid Advance Medical Directive was in existence. The treating hospital was required to constitute a Primary Medical Board composed of physicians possessing a minimum of twenty years of clinical experience to conduct an independent assessment of the patient's medical condition and prognosis.[51] Should the Primary Board conclude that withdrawal was clinically warranted, its findings were required to be independently verified by a Secondary Medical Board constituted under the authority of the Chief District Medical Officer.[52] Only thereafter could the matter proceed to the Judicial Magistrate of the First Class, who was further required to personally visit the patient at the hospital and satisfy themselves that all prescribed criteria had been fulfilled before any lawful withdrawal of treatment could take place.[53]

The manifest intention underlying this layered framework was the prevention of abuse. In practice, however, the consequences were profoundly counterproductive. Intensive care medicine operates within acutely compressed temporal parameters, where a patient's physiological condition can deteriorate with a rapidity that administrative and judicial processes are entirely ill-equipped to match. The requirement of convening district-level medical boards, securing the independent endorsement of a separate governmental body, and awaiting the personal attendance of a judicial magistrate at the patient's bedside introduced delays that directly contradicted the judgment's own stated purpose of sparing terminally ill patients from

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[49] Common Cause v. Union of India, (2018) 5 SCC 1, ¶ 244 (India).

[50] *Id.* at ¶ 189–191.

[51] *Id.* at ¶ 192.

[52] *Id.* at ¶ 193.

[53] *Id.* at ¶ 194–195.

prolonged and undignified suffering.[54] The inevitable consequence was a condition of profound implementation paralysis, a situation in which the *Common Cause* judgment, for all its constitutional grandeur, proved nearly as inaccessible in clinical practice as the framework it had been intended to supersede.[55]

This fundamental tension between constitutional aspiration and operational reality would necessitate the further judicial recalibration that eventually arrived through the Supreme Court's 2023 modifications, the subject of which the analysis next turns to.

V. THE 2023 SUPREME COURT CLARIFICATIONS AND THE HARISH RANA JUDGMENT (2026)

The implementation paralysis that had come to characterise the *Common Cause* framework in clinical practice did not go unaddressed by the medical community. Recognising that the constitutional right affirmed in 2018 had been rendered functionally hollow by the procedural architecture designed to protect it, the Indian Society for Critical Care Medicine filed a miscellaneous application before the Supreme Court in 2019, formally urging the Court to reconsider and substantially simplify the procedural conditions that had rendered the guidelines unworkable.[56] The medical community's submissions were unambiguous: the mandatory involvement of judicial magistrates and district-level governmental functionaries in acutely time-sensitive clinical decisions had erected insurmountable institutional obstacles, effectively converting a fundamental constitutional right into an administrative impossibility for the overwhelming majority of patients and their families.[57]

A. The 2023 Modifications: A Structural Recalibration

On January 24, 2023, a five-judge Constitution Bench of the Supreme Court responded to these compelling concerns by issuing a comprehensive set of modifications to the 2018 procedural framework.[58] The essential character of this recalibration was a decisive shift in the locus of oversight away from a judicially heavy, bureaucratically encumbered process and toward a streamlined model of medical professional accountability. The 2023 clarifications thus

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[54] *See* Common Cause v. Union of India, W.P. (C) No. 215/2005, Order dated January 24, 2023, ¶ 3 (Supreme Court of India) (acknowledging the procedural burden generated by the 2018 framework as the primary impetus for modification).

[55] See generally Mrinal Satish & Aparna Chandra, Dignity in Dying: Revisiting Common Cause, 11 NUJS L. REV. 1, 14–18 (2018).

[56] Indian Society for Critical Care Medicine, Miscellaneous Application in Common Cause v. Union of India, W.P. (C) No. 215/2005 (Supreme Court of India, filed 2019).

[57] *See* Common Cause v. Union of India, W.P. (C) No. 215/2005, Order dated January 24, 2023, ¶ 3 (Supreme Court of India).

[58] *Id.* at ¶ 1.

represented not a dilution of the safeguards against abuse, but rather a more intelligent and clinically sensitive calibration of where those safeguards should be located and how they should operate.

(i) Simplification of Advance Medical Directive Execution

The most immediately impactful modification concerned the authentication of living wills. The 2018 requirement that an Advance Medical Directive be countersigned by a Judicial Magistrate of the First Class, a condition that had proven both logistically burdensome and temporally impractical, was eliminated entirely.[59] Under the revised framework, a living will is now legally valid upon attestation by a Notary Public or a Gazetted Officer, a change that dramatically reduces the procedural cost and complexity of executing such a document and brings the process within the realistic reach of ordinary citizens.[60]

(ii) Rationalisation of Medical Board Requirements

The modifications also substantially rationalised the constitution and composition of the medical boards responsible for evaluating withdrawal decisions. The experience threshold for physicians serving on both the Primary and Secondary Medical Boards was reduced from the previously mandated twenty years to a more practically attainable five years, an acknowledgement of the genuine constraints on specialist availability across Indian healthcare institutions, particularly outside metropolitan centres.[61] The mandatory involvement of the Chief District Medical Officer in the Secondary Medical Board was similarly dispensed with; under the revised scheme, the District Medical Officer retains the authority to nominate a representative to serve on the board, and the total membership of the Secondary Board was capped at three, ensuring both manageability and speed of deliberation.[62]

(iii) Temporal Parameters and Transfer of Decision-Making Authority

Perhaps the most consequential modifications pertained to the temporal and decisional dimensions of the withdrawal process. The Court introduced a preferred forty-eight-hour timeframe within which the medical boards are expected to render their clinical opinions, a provision directly responsive to the criticism that administrative delays under the 2018 framework had themselves become a source of the very prolonged patient suffering the entire exercise was designed to prevent.[63]

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[59] *Id.* at ¶ 6.

[60] *Id.* at ¶ 7.

[61] *Id.* at ¶ 9.

[62] *Id.* at ¶ 10.

[63] *Id.* at ¶ 11.

Most significantly, the 2023 clarifications fundamentally restructured the role of the Judicial Magistrate or District Magistrate in the final stage of the process. Under the 2018 framework, the magistrate's formal authorisation was an indispensable precondition for any lawful withdrawal of treatment. The revised framework replaces this requirement with a mere obligation of intimation; the relevant magistrate needs only to be informed of the medical boards' unanimous decision, rather than being required to issue independent authorisation.[64] This structural change effectively and appropriately returned the locus of decision-making authority to treating physicians and the patient's next of kin, where both clinical logic and constitutional principle suggest it properly belongs.

These modifications were received with considerable relief and approval across the intensive care community. By materially reducing the legal friction that had previously incentivised families and physicians to opt for informal, legally ambiguous discharges against medical advice in preference to the structured, dignified, and legally compliant withdrawal of treatment, the 2023 clarifications meaningfully advanced the prospect of compassionate end-of-life care being realised in practice rather than merely affirmed in theory.[65]

B. Harish Rana v. Union of India (2026): Operational Crystallisation

The practical viability and sufficiency of the streamlined 2023 framework received its most decisive judicial validation in the Supreme Court's landmark 2026 pronouncement in *Harish Rana v. Union of India,* a judgment that marks the most recent and, in several respects, the most operationally significant milestone in the evolution of Indian end-of-life jurisprudence.[66]

The case concerned a patient who had remained in a permanent vegetative state for thirteen years, presenting the Court with the opportunity to apply the revised procedural framework in a concrete clinical context and to resolve several outstanding definitional ambiguities that the 2018 judgment had left unaddressed. The Supreme Court duly authorised the withdrawal of Clinically Assisted Nutrition and Hydration, the provision of food and fluids through medical devices, formally and explicitly classifying it as a form of medical treatment susceptible to lawful withdrawal under the established framework.[67] This determination was of considerable practical significance: the question of whether artificial nutrition and hydration constituted "medical treatment" or merely "basic care" had been a persistent source of clinical and legal

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[64] *Id.* at ¶ 12–13.

[65] See generally Sheetal Sharma, Dying with Dignity: India's Evolving Euthanasia Framework, 14 INDIAN J.L. & SOC'Y 45, 58–61 (2023).

[66] Harish Rana v. Union of India, (2026) (Supreme Court of India).

[67] *Id.* (classifying Clinically Assisted Nutrition and Hydration as medical treatment subject to lawful withdrawal under the *Common Cause* framework as modified in 2023).

uncertainty, and its resolution in *Harish Rana* removed one of the most consequential ambiguities impeding the implementation of withdrawal decisions in long-term vegetative state cases.

Equally notable was the Court's deliberate and considered departure from the terminology of "passive euthanasia." The judgment mandated the prospective adoption of the expression "withholding and withdrawal of medical treatment" in both judicial and clinical discourse.[68] This terminological recalibration was not merely semantic; it was jurisprudentially purposeful, severing the conceptual association between the lawful withdrawal of futile treatment and the morally and legally distinct act of active, intentional killing, and thereby eliminating a persistent source of confusion that had complicated both public understanding and clinical implementation of the governing legal framework.

VI. COMPARATIVE JURISPRUDENCE

A critical appraisal of India's judicial approach to end-of-life decision-making would remain incomplete without situating it within the broader landscape of global legal frameworks governing euthanasia and physician-assisted dying. Such a comparative exercise is not merely academically instructive; it is normatively indispensable, illuminating the range of philosophical and legislative choices available to legal systems wrestling with the same fundamental tension between individual autonomy and the state's interest in the preservation of human life. The jurisdictions examined below represent meaningfully distinct points along that philosophical spectrum, and together they provide a valuable analytical lens through which the distinctive contours and limitations of the Indian approach may be assessed.

A. Comparative Overview

Jurisdiction	Legal Status of Active Euthanasia	Legal Status of Physician Assisted Dying (PAD)	Core Underlying Philosophy and Safeguards
India	**Strictly prohibited**	**Strictly Illegal**	Prioritises sanctity of life; permits only the withholding or withdrawal of futile medical treatment through Advance Medical Directives or the best interests

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[68] *Id.* (directing prospective use of "withholding and withdrawal of medical treatment" in place of "passive euthanasia" in judicial and clinical contexts).

			doctrine; oversight vested in multi-tiered medical boards; all positive acts intended to cause death remain absolutely prohibited.
Netherlands	**Legal since 2002**	**Legal**	Anchored in patient autonomy; permits active euthanasia where a patient experiences unbearable suffering with no prospect of improvement; subject to mandatory reporting to regional review committees; uniquely extends eligibility to cases involving severe, treatment-resistant psychiatric illness under prescribed conditions.
Belgium	**Legal since 2002**	**Legal**	Closely mirrors the Dutch model; recognises a moral and legal imperative to relieve overwhelming suffering; incorporates a robust national palliative care infrastructure as a complementary framework; euthanasia requests for non-terminal psychological suffering are permissible under strict substantive criteria.
United States (e.g., Oregon)	**Illegal in all states**	**Legal in select states**	The Oregon Death with Dignity Act permits physician-assisted dying exclusively for terminally ill patients with a prognosis of six months or less; the patient must self-administer the prescribed lethal medication, preserving ultimate volitional control; active

			administration by the physician remains categorically prohibited.

B. Analysis of Comparative Frameworks

The comparative data presented above reveal a discernible philosophical gradient across these jurisdictions. At one end of the spectrum, Belgium and the Netherlands have adopted frameworks that afford primacy to the principle of absolute patient autonomy, permitting not merely the withdrawal of treatment but the active administration of life-ending measures even, in carefully delineated circumstances, in cases involving non-terminal psychological suffering of sufficient severity and intractability.[69] These frameworks reflect a normative judgment that a state's obligation to respect the self-determined choices of its citizens extends, at the outer limit, to facilitating a chosen death where continued existence has been rendered genuinely unbearable and irreversibly so.

The United States model, as exemplified by the Oregon Death with Dignity Act, occupies a philosophically intermediate position. It acknowledges the legitimacy of patient autonomy in end-of-life decision-making to a degree that Indian law does not, permitting physician-assisted dying for qualifying terminal patients, yet it preserves a categorical prohibition on active euthanasia and introduces the requirement of patient self-administration as an institutional safeguard that serves simultaneously as a test of autonomous volition and a final barrier against the physician assuming the direct role of life-terminator.[70]

C. India's Position and the Slippery Slope Concern

India, by contrast, occupies the most conservative end of this comparative spectrum. The Indian Supreme Court has been demonstrably attentive to comparative jurisprudence in crafting its rulings not as a source of doctrines to be imported wholesale, but as a body of experience that illuminates the risks of over-extension. A persistent and explicitly articulated concern in both *Common Cause* and *Harish Rana* is the avoidance of what the Court characterises as the "slippery slope”, the gradual erosion of the boundary between the lawful withdrawal of futile treatment and the unlawful active administration of death.[71]

The judiciary has pursued this objective with considerable methodological care. By expressly classifying Clinically Assisted Nutrition and Hydration as medical treatment susceptible to

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[69] Act on Euthanasia 2002 (Belg.); Termination of Life on Request and Assisted Suicide Act 2002 (Neth.).

[70] Oregon Death with Dignity Act, OR. REV. STAT. § 127.815.

[71] Common Cause v. Union of India, (2018) 5 SCC 1, ¶ 245 (India); Harish Rana v. Union of India, (2026) (Supreme Court of India).

lawful withdrawal rather than as basic care that must be continued irrespective of prognosis, the Court in *Harish Rana* extended the permissible scope of passive omission as far as the constitutional and normative framework appears to allow, without crossing into the domain of active, positive acts of life-termination.[72] Similarly, the terminological shift from "passive euthanasia" to "withholding and withdrawal of medical treatment" serves the deliberate function of reinforcing the conceptual and legal distance between India's permissible framework and the active euthanasia regimes operative in European jurisdictions.[73]

This conservative but gradually expansive trajectory reflects the Court's awareness that India presents contextual challenges in terms of medical literacy, socio-economic vulnerability, healthcare infrastructure, and social security that are qualitatively different from those confronting Western European or North American legal systems. The comparative lesson that Indian jurisprudence appears to have drawn is not that other jurisdictions are wrong, but that legal transplantation without contextual sensitivity carries its own distinctive risks and that a measured, incrementally progressive framework may, in the Indian context, better serve the constitutional values of dignity and autonomy than an abrupt legislative leap toward active euthanasia.

VII. ETHICAL AND LEGAL DILEMMAS

The attainment of judicial clarity regarding the legal permissibility of withholding and withdrawing life-sustaining treatment has not, by any means, resolved the deeper normative landscape within which end-of-life decisions are actually made. Beneath the constitutional architecture constructed by the Supreme Court lies a complex and contested terrain of ethical, theological, and professional dilemmas that continue to shape and, in many instances, obstruct the practical realisation of the right to die with dignity in India. Three categories of tension merit particular analytical attention.

A. The Philosophical Conflict: Autonomy Versus the Sanctity of Life

At the most foundational level, the debate over euthanasia in any form reflects an unresolved philosophical confrontation between two competing moral traditions. On one side stands the utilitarian and liberal conception of individual autonomy, which holds that a competent person's self-determined choices regarding their own body and the circumstances of their death are entitled to the highest degree of legal and moral respect.[74] On the other hand, stands the

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[72] Harish Rana v. Union of India, (2026) (Supreme Court of India).

[73] Id.

[74] *See* Common Cause v. Union of India, (2018) 5 SCC 1, ¶ 223 (India); *see also* JOHN STUART MILL, ON LIBERTY 13–14 (1859).

deontological commitment to the intrinsic and inviolable sanctity of human life, the conviction that human existence possesses an unconditional moral value that cannot be extinguished or discarded even at the request of the individual concerned, and that permitting its termination, however passively, fundamentally degrades the moral fabric that protects all human beings.[75]

This latter perspective frequently manifests in what is commonly termed the "slippery slope" argument, the contention that once society accepts the withdrawal of life-sustaining care for terminally ill patients, it inevitably sets in motion a process of normative erosion that progressively devalues the lives of other vulnerable populations.[76] On this view, the elderly, the severely disabled, and those whose continued care imposes substantial financial burdens upon their families or upon the state become, over time, candidates for a calculus of disposability, a prospect that critics regard as incompatible with any genuinely humane legal order.[77] While the Supreme Court has acknowledged and engaged with this concern in its procedural architecture, the philosophical debate it reflects remains very much alive and continues to animate resistance to the implementation of even judicially sanctioned withdrawal decisions.

B. Religious and Cultural Pluralism

In a society as religiously and culturally diverse as India, theological doctrine exercises a pervasive influence over medical ethics and end-of-life decision-making, one that operates independently of, and frequently in tension with, the legal framework established by the courts. The principal religious traditions represented in India each bring a distinctive normative orientation to the question of life termination, and their divergences are consequential for clinical practice.

Within the Hindu tradition, the sanctity of life is deeply embedded in cosmological and karmic frameworks. The artificial interruption of the dying process is widely understood to interfere with the natural progression of the soul through its karmic cycle, and is therefore regarded by many adherents as spiritually impermissible.[78] It bears noting, however, that the tradition is not without internal complexity. The practice of *Santhara*, a voluntary and ritually governed fast unto death observed by Jain practitioners and acknowledged in certain Hindu philosophical

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[75] *See generally* JOHN KEOWN, EUTHANASIA, ETHICS AND PUBLIC POLICY: AN ARGUMENT AGAINST LEGALISATION 39–52 (2d ed. 2018).

[76] *Id.* at 66–70.

[77] See Yale Kamisar, Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation, 42 MINN. L. REV. 969, 1030–32 (1958).

[78] *See* P.V. KANE, HISTORY OF DHARMAŚĀSTRA, VOL. II, PT. I, 925–27 (1974) (discussing Hindu philosophical frameworks governing the sanctity of life).

traditions, reflects a historically recognised form of self-willed death that the tradition treats as spiritually meritorious rather than morally transgressive.[79]

Buddhism, while grounded in the principle of *ahimsa,* non-harm to all sentient beings, simultaneously accords great moral weight to the imperative of alleviating suffering, and its classical texts contain a degree of philosophical nuance regarding end-of-life conduct that does not admit of simple prohibitory conclusions.[80] The Abrahamic faiths, Christianity and Islam, are, by and large, considerably more categorical in their opposition. Both traditions assert an absolute divine sovereignty over the giving and taking of human life, and regard any deliberate act or, in stricter interpretations, any deliberate omission that hastens death as an impermissible usurpation of that sovereignty.[81]

These theological commitments are not merely abstract matters of personal belief. They manifest with real and immediate consequences at the bedside. Medical professionals whose personal faith aligns with traditions that prohibit the withdrawal of life support frequently experience acute moral distress when called upon, whether by a patient's family or a medical board, to participate in such decisions.[82] This reality generates a practical imperative for healthcare institutions to develop thoughtfully designed conscientious objection policies accommodating the moral integrity of individual practitioners while ensuring that patients' constitutionally recognised rights are not frustrated by the personal convictions of those responsible for their care.[83]

C. The Medical Community: Futile Care, Moral Injury, and Legal Vulnerability

For the medical community, the evolution of the legal framework has created a set of professional and psychological challenges that are no less significant for being less visible in judicial discourse. The transition from an ethic of aggressive, curative intervention to one of facilitating a dignified death requires a fundamental reorientation of professional identity, one that sits uneasily with the traditional Hippocratic commitment to the preservation of life, which has historically been understood as an absolute rather than a qualified obligation.[84]

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[79] See Nikhil Sinha, Santhara and the Right to Die: A Jurisprudential Inquiry, 7 NUJS L. REV. 213, 218–221 (2014).

[80] *See* DAMIEN KEOWN, BUDDHISM AND BIOETHICS 168–172 (2d ed. 2001).

[81] *See* TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 144–45 (8th ed. 2019).

[82] See Seema Arora et al., Moral Distress Among Critical Care Physicians in India, 18 INDIAN J. CRITICAL CARE MED. 339, 341 (2014).

[83] See Sheetal Sharma, Dying with Dignity: India's Evolving Euthanasia Framework, 14 INDIAN J.L. & SOC'Y 45, 62 (2023).

[84] *See* BEAUCHAMP & CHILDRESS, *supra* note 8, at 202–04.

In intensive care settings, this tension manifests with particular acuity in the phenomenon of "futile care”, the administration of invasive, costly, and physiologically burdensome interventions that serve no therapeutic purpose beyond the artificial prolongation of the dying process.[85] The persistence of such interventions, whether driven by familial pressure, institutional inertia, or legal caution, inflicts a measurable moral injury upon the physicians and nurses compelled to administer them, professionals who are acutely aware that the care they are providing is not in their patients’ interest yet feel legally and institutionally constrained from acting upon that clinical judgment.[86]

This legal vulnerability is not illusory. Notwithstanding the judicial recognition of passive euthanasia, the fear of prosecution for medical negligence or, in extreme cases, culpable homicide continues to exert a chilling effect upon clinical decision-making.[87] Until a comprehensive legislative framework provides clear, unambiguous, and prospective legal protection to physicians who comply in good faith with the established procedural requirements, this fear will persist and with it, the distressing paradox of a constitutionally recognised right that healthcare providers remain reluctant to honour.

VIII. CHALLENGES IN IMPLEMENTATION

The judicial and procedural reforms introduced through the 2023 modifications and operationally affirmed in *Harish Rana* (2026) have undeniably simplified the legal architecture governing end-of-life decisions in India. Yet the translation of constitutional principle into equitable clinical practice remains deeply incomplete. Several systemic and operational barriers continue to obstruct the universal realisation of the right to die with dignity, and their persistence represents a serious challenge to the integrity of the framework as a whole.

A. Inadequate Awareness and Administrative Inertia

A foundational impediment is the pervasive lack of awareness regarding Advance Medical Directives among both the general public and significant segments of the medical profession itself.[88] Even in cases where proactive and legally informed individuals have taken the initiative to execute living wills, bureaucratic inertia at the institutional level undermines their utility. State governments and local municipal bodies have been conspicuously slow in designating custodians for these directives, and hospital administrators, frequently apprehensive about

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[85] See Roop Gursahani & Parag Doshi, Futile Treatment in Indian Intensive Care: Time for a Rethink, 8 INDIAN J. MEDICAL ETHICS 78, 79 (2011).

[86] *See* Arora et al., *supra* note 9, at 343.

[87] *See* Common Cause v. Union of India, (2018) 5 SCC 1, ¶ 17 (India) (acknowledging the chilling effect of legal uncertainty on clinical practice).

[88] *See generally* Sheetal Sharma, *supra* note 96, at 63.

residual legal exposure in the absence of clear guidance from state health ministries, continue to hesitate before acting upon them.[89] The result is that a document of considerable constitutional significance is, in practice, routinely disregarded at precisely the moment it is most needed.

B. The Absence of a Digital Registry

The current legal framework's dependence upon physical documentation creates a structural vulnerability that is particularly acute in emergency clinical contexts. Intensive care units operate within acutely compressed decision-making windows; acute physiological crises rarely permit the time required to convene medical boards, locate physical copies of living wills, or engage in meaningful deliberation with distressed family members.[90] Without a centralised, securely accessible national digital registry of Advance Medical Directives integrated with individual patient health records, attending physicians have no reliable mechanism for verifying the existence or content of a living will during a midnight emergency.[91] The absence of such infrastructure renders the living will practically ineffective at the very moment its operation is most constitutionally significant.

C. Definitional Ambiguity and Familial Disputes

Indian law presently lacks precise statutory definitions for the critical concepts of "next of kin" and the hierarchical ordering of proxy decision-makers in end-of-life contexts.[92] Where a patient has not executed an Advance Medical Directive, disagreements among family members regarding the withdrawal of life-sustaining treatment can entirely paralyse the deliberative process, leading to protracted disputes and the indefinite continuation of futile, painful interventions that serve no therapeutic purpose and honour no one's interests, least of all the patient's.[93] The absence of a clear legislative hierarchy for surrogate decision-making constitutes a gap that judicial guidelines alone are insufficient to fill.

D. The Rural-Urban Divide and the DAMA Phenomenon

The sophisticated dual medical board framework prescribed by the Supreme Court presupposes rapid access to specialised clinicians, neurologists, oncologists, and critical care physicians

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[89] *See* Common Cause v. Union of India, W.P. (C) No. 215/2005, Order dated January 24, 2023, ¶ 3 (Supreme Court of India).

[90] Id.

[91] *See* Ministry of Health and Family Welfare, Ayushman Bharat Digital Mission, Government of India (2021), https://abdm.gov.in.

[92] *See* Common Cause v. Union of India, (2018) 5 SCC 1, ¶ 189 (India).

[93] *Id.* at ¶ 194.

capable of independently assessing prognosis and the futility of continued treatment.[94] In the well-resourced environment of metropolitan tertiary hospitals, this requirement, while demanding, is at least logistically feasible. In rural and district-level healthcare facilities, which serve the vast majority of India's population and frequently lack basic infrastructure, let alone specialist panels, compliance with these mandates is a near-impossibility.[95]

This infrastructural disparity, compounded by a pervasive fear of litigation, has given rise to and perpetuated a deeply troubling clinical phenomenon documented in the INDICAPS studies: the preference among physicians for discharging terminally ill patients against medical advice rather than formally overseeing the legally prescribed withdrawal of life support.[96] This practice, transferring the physical and emotional burden of a patient's death onto unprepared and often impoverished families, represents perhaps the most direct and distressing manifestation of the gap between constitutional aspiration and clinical reality in the governance of end-of-life care in India.

IX. RECOMMENDATIONS

Bridging the substantial chasm between the constitutional framework's theoretical promise and its equitable clinical delivery requires coordinated, multi-dimensional reform targeting both the legal and healthcare ecosystems. The following recommendations are advanced as essential prerequisites for the meaningful realisation of the right to die with dignity across the full breadth of Indian society.

A. Comprehensive Parliamentary Legislation

The most urgent and consequential recommendation is for the Parliament of India to enact a standalone, comprehensive statute governing end-of-life care.[97] While the Supreme Court and, most recently, the *Harish Rana* judgment have commendably filled the legislative vacuum through judicial interpretation, the inherent limitations of judge-made law in terms of administrative reach, institutional specificity, and democratic legitimacy render this an inadequate long-term substitute for parliamentary action.[98] A dedicated End-of-Life Care Act, constructed upon the foundations provided by the Law Commission's previous draft recommendations, should accomplish several critical objectives: providing unambiguous

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[94] *Id.* at ¶ 192.

[95] *See* Gursahani & Doshi, *supra* note 98, at 80.

[96] See Roop Gursahani et al., End-of-Life Care in Indian ICUs: The INDICAPS Study, 20 INDIAN J. CRITICAL CARE MED. 149, 153 (2016).

[97] Harish Rana v. Union of India, (2026) (Supreme Court of India).

[98] *Id.*; *see also* LAW COMMISSION OF INDIA, REPORT NO. 241: PASSIVE EUTHANASIA A RELOOK (2012).

statutory immunity to medical practitioners who comply in good faith with prescribed procedures; establishing a clear and legally binding hierarchy of proxy decision-makers for patients lacking Advance Medical Directives; standardising the withdrawal process across all healthcare institutions nationwide; and definitively removing the residual shadow of criminal prosecution under the Indian Penal Code that continues to generate physician hesitancy.[99]

B. National Digital Registry for Advance Medical Directives

The Ministry of Health and Family Welfare must establish a secure, nationally accessible digital repository for Advance Medical Directives as a matter of immediate priority.[100] Integration of this registry with individual patient health records under the Ayushman Bharat Digital Mission would enable emergency physicians to instantaneously access, authenticate, and act upon a patient's prospective end-of-life instructions, eliminating the bureaucratic obstacle of locating physical documents and tracing municipal custodians during acute clinical crises, and ensuring that a patient's constitutionally protected wishes are not frustrated by administrative failure.[101]

C. Investment in Palliative Care Infrastructure

As the *Harish Rana* judgment itself made clear, the withdrawal of life-sustaining treatment must never be permitted to become synonymous with the abandonment of the patient.[102] The legal authorisation to withdraw futile treatment carries with it a corresponding institutional obligation to ensure that the patient's transition is accompanied by comprehensive, compassionate palliative care. India must substantially increase state investment in and specialist training for palliative medicine, elevating it from its current status as a peripheral sub-speciality of oncology to a core, mandatory component of critical care and general medical curricula.[103] A dignified death requires not merely the removal of burdensome treatment but the active provision of comfort, pain relief, and human presence.

D. Public Awareness and Cultural Sensitisation

Finally, state health departments in sustained collaboration with the Indian Medical Association, the Indian Society of Critical Care Medicine, and civil society organisations must develop and implement extensive, culturally sensitive public awareness campaigns aimed at destigmatising conversations about death, dying, and advance care planning.[104] The right to die

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[99] Indian Penal Code, 1860, §§ 299, 304, 306 (India).

[100] Ministry of Health and Family Welfare, Ayushman Bharat Digital Mission, Government of India (2021), https://abdm.gov.in.

[101] Id.

[102] Harish Rana v. Union of India, (2026) (Supreme Court of India).

[103] *See* Gursahani & Doshi, *supra* note 98, at 81.

[104] *See* Sheetal Sharma, *supra* note 96, at 65.

with dignity cannot be equitably realised if knowledge of its existence and exercise remains the exclusive province of the legally literate urban professional class. Normalising these conversations across diverse linguistic, cultural, and socio-economic communities is an indispensable condition for the transformation of constitutional entitlement into lived reality.

X. CONCLUSION

The judicial arc traced from the categorical prohibition affirmed in *Gian Kaur* (1996) to the operational compassion achieved in *Harish Rana* (2026) represents one of the most remarkable and consequential evolutions in the history of Indian constitutional jurisprudence. Through a sequence of increasingly sophisticated pronouncements, the Supreme Court of India has accomplished what the legislature has persistently failed to undertake: the construction of a normative framework that meaningfully reconciles the constitutional imperative of human dignity with the practical realities of modern medical technology, terminal illness, and the limits of curative medicine.

By reading the right to die with dignity into the expansive and living ambit of Article 21, the Court successfully disentangled the withdrawal of futile medical treatment from the archaic penal categories of culpable homicide and abetment to suicide, a doctrinal clarification of enduring importance.[105] The progression from the procedurally inaccessible *Aruna Shanbaug* framework to the constitutional landmark of *Common Cause*, and subsequently to the pragmatically recalibrated 2023 clarifications, reflects a judiciary possessed of the institutional self-awareness and doctrinal flexibility to correct its own inadequacies in response to clinical experience and the principled advocacy of the medical community.

The *Harish Rana* judgment of 2026 stands as the definitive capstone of this evolution, demonstrating that the legal apparatus of the Indian state is capable of navigating the profound intersection of medicine, morality, and mercy with sensitivity and constitutional rigour.[106] Its recognition of Clinically Assisted Nutrition and Hydration as medical treatment susceptible to lawful withdrawal, and its deliberate terminological shift from "passive euthanasia" to "withholding and withdrawal of medical treatment," together affirm the Court's enduring commitment to a framework in which the preservation of human dignity rather than the perpetuation of biological existence at any cost remains the paramount constitutional value.[107]

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[105] Gian Kaur v. State of Punjab, (1996) 2 SCC 648 (India); INDIA CONST. art. 21.

[106] Harish Rana v. Union of India, (2026) (Supreme Court of India).

[107] Id.

Yet constitutional recognition, however eloquent and however hard-won, constitutes only the first chapter of the story. The authentic test of this jurisprudence lies not in the pages of the Supreme Court Reports but in the wards of district hospitals, the homes of rural families, and the daily clinical decisions of physicians across a vast and profoundly diverse nation. Until Parliament enacts comprehensive statutory legislation that codifies judicial principles into accessible, digitally integrated, and culturally sensitive law, the right to die with dignity will remain, for the overwhelming majority of Indians, a theoretical entitlement rather than a practical one accessible in the elite corridors of urban tertiary care but effectively unavailable to those for whom its compassionate promise matters most.

Moving forward, India must consciously and purposefully cultivate a healthcare ecosystem in which palliative care and advanced care planning are normalised features of medical practice rather than exceptional interventions. The constitutional promise of dignity is indivisible; it must extend unconditionally to the final, most vulnerable, and most profoundly human moments of every life.

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