

Euthanasia and the Right to Die in India: Constitutional Dimensions and Judicial Evolution

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ABSTRACT:

Background: A person having a constitutionally judicable right or privilege to control the conditions and timing of their own death, especially where that person is faced with an irreversible terminal illness, or a severe neurological disorder, or a permanent unconscious state of being, is one of the most hotly disputed interface of biomedical ethics, basic rights jurisprudence and the capability of parliament to act in such situations under Indian constitutional law.

Objectives: To implement a vigorous constitutional and judicial review of the developing death-with-dignity framework in India; to analyze the doctrinal value of Harish Rana v. Union of India (2026) as the first judicial review of implementing the Common Cause model to a specified patient in a definite factual grid.

Case Laws: The Harish Rana decision (2026) propounded three legal propositions that interrelate to each other: first, that Clinically Assisted Nutrition and Hydration (CANH) is medical treatment, which can be withdrawn legally; second, that a best-interest determination should involve both substituted and non-clinical factors; and lastly, that the State has an institutional duty to establish district-level Medical Boards. Despite all these developments, there are still critical gaps in implementation such as insignificant level of public awareness on Advance Directives, incomplete state of the palliative care ecosystem, and the still lacking governing law.

Conclusion: Although some degree of jurisprudential maturity has been achieved in the constitutional structure of India, the practicality of achieving the right to die with dignity has failed to achieve structural correctness, leaving most of the terminally ill individuals without the opportunity of enjoying a dignified death. Parliamentary laws--enactment of which, under the joint influence of Common Cause and Harish Rana has become constitutionally binding--can no longer be considered as a wise reform; it has taken the quality of a constitutional imperative.

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1. Introduction

The certainty of human existence is death and the legal framework by which this fate comes and when it comes is one of the most philosophically and constitutionally controversial areas of modern jurisprudence. By having to decide whether that patient has any legally cognisable claim to the conditions of their dying where that person faces an irremedial terminal diagnosis, progressive deterioration of his or her neurological functions, or a similarly extended unconscious state with no medically orthodox hope of recovery, we are placed in the belly of the constitutional democracy: bodily autonomy, personal sovereignty, human dignity and right to self-determination.

The arc of jurisprudence is striking, moving from the judiciary's unequivocal rejection of a right to die in *Gian Kaur v. State of Punjab*¹ to the cautious recognition of passive euthanasia in *Aruna Ramchandra Shanbaug v. Union of India*,² as well as *Harish Rana* is important not primarily because it reaffirmed the existing doctrine in the abstract but simply because it functioned to do this by operational translation: the Court did not simply recognize an existing constitutional right since 2018 on paper but actively - It actually operationalised its clinical implementation, turning what was a framework dedicated due to the law reports during its existence almost solely to the paper now into an execution pattern, over whose consequences to life and death lie and death.

Following this legal breakthrough, there is still a lack of a detailed legislative framework of euthanasia and end-of-life care in India. In the Rajya Sabha there is Medical Treatment of Terminally Ill Patients (Protection of Patients and Medical Practitioners) Bill, 2016 which was not enacted and ended by lapse. The gap between the constitutional vision of Common Cause and progressive refined to *Harish Rana* on the one

hand, and the reality of legislative and clinical nursing and dying patients and families on the other side, is wide and ethically unsustainable.

2. Scope and Method of Research.

This paper applies a methodological approach of doctrinal legal research. It follows a methodical examination and critical review of primary legal sources: constitutional texts, Supreme Court and High Court decisions, legislative text, and secondary sources of sources: academic commentary, comparative legal studies, and national and global health organisation policy papers.

The main sources of cases are the reported judgments made by the Supreme Court of India, with a particular emphasis on five landmark cases between 1994 and 2026. Legal documents consist of both passed laws, and unsuccessful Bills. Comparative materials are selected based on five jurisdictions, the Netherlands, Belgium, Switzerland, Canada, and the United Kingdom, with the jurisdictions chosen based on their impacts on Indian jurisprudence in terms of doctrines and the differences in their variety of regulatory forms.

The area is limited to both the law on passive euthanasia and physician-assisted dying because they are legally different to active euthanasia. Active euthanasia is treated only as a distinction and study of the boundary of active and passive. The *Harish Rana* case (2026 INSC 222), decided on 11 March 2026, is discussed as the end point of the Indian judicial history, and is examined in the most detail, as it was the first practical applying of the Common Cause model. The article fails to discuss legislative changes, should any occur, that have taken place beyond 2026 in April.

3. Conceptual and Ethical Framework.

3.1 Definitional Taxonomy

Euthanasia has been coined by combining the Greek words eu (good) with thanatos (death), and has in the past been used to refer to intentionally taking away a life that is full of suffering that cannot be cured. The discipline of legal and bioethical has evolved a taxonomical system that has strong doctrinal ramifications. Active euthanasia refers to the active process of introducing, by a third party, a lethal agent, with the intentions of causing death. Passive euthanasia, in contrast, consists in the denial or removal of active medical assistance that prolongs life in order to allow the underlying pathological be facilitated to take its own course. Routine euthanasia is carried out under a prescribed request that is responsive, informed and capacitated by the patient. Non-voluntary euthanasia comes in when the patient has no means of communicating his or her choice, usually in the scenario of persistent vegetative state (PVS), and involuntary euthanasia goes on without the voice of the patient, which is viewed as equivalent to culpable homicide in any jurisdiction.

Notable is the fact that even in *Harish Rana* itself the Court indicated its preference of the more clinically accurate term withdrawal or withholding medical treatment against passive euthanasia, which it saw as all the more inaccurate and misleading. This selective wordplay puts a solid lexical ground on clinical-ethical judgement, in contrast to the stigmatised terms traditionally linked to euthanasia, and takes Indian law nearer to standard comparative practice.

Physician-assisted dying (PAD) falls under a different umbrella of the law although they are conceptually close to each other: a circumstance whereby a clinician provides the pharmacological or material resources allowing a patient to take his own life, albeit the actual taking of life is performed by the latter. It is a practice that is accorded a different status of law in some jurisdictions but still the Indian courts have not made a judgment that is direct regarding the practice.

3.2 Philosophical Foundations

Arguments in support of legal recognition of right to die are based on three main philosophical pillars. The sovereignty of a competent adult over their own body and their own life, extends, in the first instance, to the decision of how and when they die, meaning that they cannot be forcefully made to endure the humiliating, torturous, or dehumanising processes of dying. The third one is the third principle of medical ethics beneficence - the obligation to do the patient the actual good, which in some terminal situations can carry with it the obligation to discontinue introductory measures that delay the patient to suffer without therapeutic use.

Opposing arguments appeal to the sanctity of life, the Hippocratic tradition of prohibiting harm, the fear of abuse of vulnerable groups, and to the slippery slope fear that eventually limiting legal status of euthanasia may be gradually extended to include patients whose lives are considered unworthy of living by others.

These issues have motivated cautious practices in most jurisdictions such as India. The Indian judiciary has put its most advanced effort to reconcile these principles in a constitutionally grounded system; the so-called best interests standard developed in *Harish Rana*, which entails a multi-dimensional evaluation, taking into consideration estimated patient values as well as clinical judgments of futility..

4. Indian Judicial Trajectory.

4.1 P. Rathinam v. Union of India (1994)

Initial substantive Indian constitutional interaction on the issue, occurred in the zone of suicide law. In *P. Rathinam v. Union of India*,¹¹ a two judge Court ruled that the constitutional right to life contained in Article 21 also included an inverse aspect, the right not to be forcefully deprived of life, and that therefore the criminalization of attempted suicide in Section 309 of the Indian Penal Code constituted a constitutional abomination itself. The Court based this finding on the argument that a person who had tried to commit suicide was worthy of compassion and

rehabilitation and this provision could not be consistent with the dignity that was inherent in Article 21.¹²

4.2 Gian Kaur v. State of Punjab (1996)

Two years after its decision, a five-judge Constitution Bench faced Rathinam with the exception to the swing of the gavel in *Gian Kaur v. State of Punjab*. The Bench adopted the view that that the guarantee of life in Article 21 of the Constitution, as being a natural right, is a guarantee to live with dignity, and that the natural entitlement to die is structurally incompatible with any entrusting or concomitant right to die. But there was a qualifying aspect to this reasoning of the Court: it made a delicate distinction between, on the one hand, a freestanding right to die on command (guaranteed by the Constitution itself), and, on the other, a contextually conditioned right to end one's life in such a circumstance as would otherwise undermine the constitutional value of dignity beyond repair. The suggestion, that a constitutional right to die with dignity must, logically speaking, in the ultimate extreme, be extended, in a like dignity, to the right to die passively, was expressly made, though without extended explanation, in *Gian Kaur* itself, but it was on this conceptual basis that, subsequently, passive euthanasia would be accepted by the courts.¹³

4.3 Aruna Ramchandra Shanbaug v. Union of India (2011)

Aruna Shanbaug case brought before the Supreme Court left behind an example of human tragedy of the first degree. Aruna Ramchandra Shanbaug was a nurse who worked at King Edward Memorial Hospital, in Mumbai, who had been in a persistent vegetative state since 1973, following an beat-up inflicted on her.¹⁴ To have herself passed out of life, a petition on her behalf was filed by journalist Pinki Virani to seek the court to authorize her withdrawal of feeding and hydration. What in any practical sense amounted to a petition to sanction passive euthanasia.

The Court refused to grant the specific relief, but the Court established in principle that passive euthanasia would be legally permissible subject to

specified conditions; and second, that such withdrawal could be authorised in a High Court, under the *parens patriae* jurisdiction, on application of a recommendation by a medical board, under Article 226.¹⁵

This decision was however criticised due to its narrow scope, as it only applied to PVS patients, it had to be authorised by the High Court and it did not make any provision regarding Advance Directives or the entitlement of a cognitively capable patient to decline proposed medical intervention.¹⁶

4.4 Common Cause v. Union of India (2018)

The ultimate constitutional pronouncement on the right to die with dignity was made in *Common Cause (A Registered Society) v. Union of India* in which a five-judge Constitution Bench was concerned.¹⁷ The Bench determined unanimously: (i) that the entitlement to die with dignity constitutes a fundamental right secured by Article 21;¹⁸ (ii) that the power to decline medical intervention that include treatment that artificially prolongs biological existence which forms an integral dimension of the guarantee under Article 21; (iii) that Advance Directives, commonly designated as Living Wills, executed by cognitively capable adults carry legal validity and are judicially enforceable;¹⁹ and (iv) that comprehensive procedural guidelines must govern the execution and implementation of Advance Directives.²⁰

Justice D.Y. Chandrachud in his concurring opinion is somewhat more drilled in doctrine: based on the assumptions of personal autonomy, on the principle of individual self-determination, and the constitutional devotion to human dignity, he stated the principle that the interest of the State that life be preserved, according to the decision of a competent individual, refuses unwanted medical treatment, must be subordinated to the voluntary and informed decision of a competent individual. A major procedural change was made in January 2023, which requires no longer has High Court authorisation and a two-tier medical board mechanism based in a hospital.

4.5 Harish Rana v. Union of India (2026): Theory into Practice.

The most significant court verdict on euthanasia in India since Common Cause, is *Harish Rana v. Union of India*, which was decided on 11 March 2026 by a bench including Justice J.B. Pardiwala and Justice K.V. Viswanathan.²¹ Its peculiar importance consists in the fact that it is the first case where the Supreme Court used Common Cause framework to a particular set of facts, leading to an actual court order to withdraw life-sustaining treatment explicitly against an identified patient. Once the right to die with dignity had achieved a stabilized constitutional footing (eight years after), but continued to be practically unavailable, Harish Rana demonstrated that the framework can be rendered to operate effectively.²²

When he was nineteen, Harish Rana, now a student of engineering at Chandigarh, fell off the fourth floor of his home in August 2013 to suffer an otherwise devastating accident. The consequent diffuse axonal brain injury rendered him a quadriplegic with a complete disability rating. He then was kept on Clinically Assisted Nutrition and Hydration (CANH) via a Percutaneous Endoscopic Gastrostomy (PEG) tube. Various independent medical assessments made during the next 10 years have repeatedly reported no presence of spatial awareness, lack of ability to engage functionally, and loss of brain structures indicative of permanent PVS. Thirteen years of home-based care was applied by his family who followed all possible medical options and used all personal resources.²³

In 2024 the father of Harish Rana appealed to the Delhi High Court to ask the court to approve the termination of life-sustaining treatment being provided to his son. The High Court refused the petition as it would mean that deliberate starvation would be done by the removal of a feeding tube instead of passive extinguishing as in the case of the removal of mechanical ventilation and thus constitute active rather than passive euthanasia.²⁴ Although a theologically fallacious argument as a comparative jurisprudence matter, it revealed a long-standing retrieval confusion in the Indian

medical and legal culture on how to appropriately classify CANH.²⁵

4.5.1 Ratio Decidendi and Key Legal Holdings

The ratio of the Harish Rana judgment includes three holdings, which are interconnected. First, the Court determined that CANH which includes nutrition and hydration by PEG tube or nasogastric tube is "medical treatment" under the Common Cause framework, and thus can be lawfully withdrawn in cases where its continuation does not promote the best interests of the patient and does not provide more than merely a vegetative existence to the patient. Indian law was decisively overruled by the rationale of the Delhi High Court, in line with Indian law, and with the jurisprudence of the various other jurisdictions.²⁶

Second, the Court significantly elaborated on the best interests standard that Common Cause had formulated but had not elaborated. Based on cross-jurisdictional analysis across seven legal systems, the Court determined that a best interests test could not be limited to a purely clinical finding of medical futility but had to encompass non-clinical factors, such as the past and present wishes and values inferred by the patient themselves, their relationships and experience, and the entire spectrum of burdens involved in further treatment. The Court described this as a balance-sheet exercise that includes a powerful substituted judgment component: decision-makers must, where possible, put themselves in the position of the patient, and ask themselves what the patient would have preferred had he or she been competent.²⁷

Third, the Court reaffirmed and deepened its request to Parliament that it must provide thorough legislation on end-of-life care without further delay, and made it clear that, without a statutory framework, the withdrawal decision-making process will be susceptible to manipulation by irrelevant factors like family financial depletion, insufficient insurance, or socio-economic susceptibilities.²⁸

5. Constitutional Framework: Common Cause to Harish Rana.

5.1 The Right to Die with Dignity in Article 21.

Common Cause has its roots in the constitutional design itself which has entrenched the promise of life and individual liberty in Article 21. The Court makes its analysis along some cross-strands of doctrines. It begins with the application of the *Puttaswamy* model to the right to privacy - specifically to the dimensions of decisional autonomy and bodily integrity - to the medical decision making process, describing the preferences of a patient as to whether to accept or reject the proposed treatment as a fundamental act of personal choice that is constitutionally secured.²⁹

The Court also creates dignity as a constitutional value, which is independent. Based on reading the Preamble of the commitment to ensuring the dignity of all citizens concomitant to Articles 14, 19, and 21 and with reference to international human rights instruments, the Court believes that constitutional dignity does not drain itself in the way of living, but also to the way of dying. An extended artificial life - a body without brain and maintained merely by some robot contrivance - is not honouring to the dignity of the individual; it is an insult to it.³⁰

The third strand of the doctrines is based on the principle of informed consent according to which the uncomplicated rejection of medical treatment by the adult individual, even the treatment, which artificially extends biological life, by the mentally competent individual is, according to the law, binding on treating clinicians and in the bequest. Forcing a patient who is unwilling to comply with the therapeutic treatment would be a breach of Article 21, which would reduce the person who has rights to carrying out the medical treatment as an active participant, and would turn into an active object of medical intervention.³¹

5.2 Harish Rana and the Deepening of Article 21 in doctrine.

The Harish Rana judgment enriches the Article 21 scrutiny on Common Cause in various significant

ways. More importantly,³² it is believed that the upholding of CANH on behalf of Harish Rana places him in a degraded condition in which his life is worth going on only with the help of artificial life support, with no consciousness, no memory, and no future to look forward to, a position that the dignity guarantee of Article 21 cannot tolerate.³³

The ruling is also a substantial extension of the right to die with dignity since it is extended to a patient who had not signed an Advance Directive. Harish Rana affirms that the Article 21 protection of dignity applies to non-voluntary passive euthanasia, situations in which there is no prior directive, to the extent of strict observation of the procedural safeguards and the best interests test is strictly followed.³⁴

5.3 Active Passive Distinction and Advance Directives.

After *Aruna Shanbaug, Common Cause* affirms that passive euthanasia is the only legal form of euthanasia in India. Active euthanasia is a criminal offense according to the *Bharatiya Nyaya Sanhita*, 2023.³⁵ omission in the law, not an act, and the withdrawal of a CANH is an omission, a doctrinally critical contribution by Harish Rana to a legal and not a merely philosophical distinction. This position, which

corresponds to *Airedale NHS Trust v. Bland* and the Dutch statutory model, is doctrinally fundamental: otherwise, the whole Common Cause model will be vulnerable to the contention, which was successfully made in the Delhi High Court, that any physical withdrawal act amounts to active euthanasia.³⁶

Common Cause is most operationally important in that it acknowledges the legality of Advance Directives documents signed by competent adults indicating which medical treatment they would like to be provided or which they would refuse in case of future incapacitation. The Court also found that Advance Directives are enforceable based on the basic right to self-determination under Article 21.³⁷ The stipulated procedural criteria would consist of: performance in the presence of two non-combatant witnesses;

performance before the Judicial Magistrate of the First Class (JMFC); handing over the attested document to the Judicial Magistrate and the local medical officer; and notification of the directive to treating hospitals.³⁸

6. The Procedural Framework

6.1 Guidelines 2018, the 2023 Modification and Harish Rana Refinements.

Under its authority under Article 142, the Supreme Court in *Common Cause* made detailed guidelines to regulate the procedure until parliamentary legislation, differentiating between incapacitated patients (those in PVS without Advance Directives) and those whose Advance Directives were valid.⁴⁰ The January 2023 amendment made this requirement less stringent. Authorisation of the termination of life-prolonging treatment should be permitted under a medical board constituted by a hospital (including at least three qualified practitioners, of whom at least one specialist in the appropriate field) with notice to a Judicial Magistrate, and without any previous sanction by the High Court.⁴¹

The Harish Rana judgment adds another institutional step to this structure, instructing the Union Government to make sure that Chief Medical Officers in all districts form and maintain panels of qualified practitioners to be appointed to Secondary Medical Board, and to instruct High Courts to give administrative direction to Judicial Magistrates on the procedures to be followed in receiving and acting upon unanimous Medical Board decisions. These systemic instructions transform the Common Cause instructions as a design of a guide to be used by individual litigants to a national administration outline.⁴²

6.2 The Issue of the JMFC Attestation.

The fact that Advance Directives must be attested by a JMFC has received longstanding practical criticism. JMFC attestation, which requires the appearance of the individual to a judicial officer, is compared to the notarisation or attestation before a Gazetted Officer,⁴³ which is both administratively cumbersome and can be intimidating, which explains its legislative reform

direction, which is to replace the JMFC with a primary attestation authority such as a Notary Public or Gazetted Officer.⁴⁴

7. Comparative Analysis

7.1 The Netherlands

Both euthanasia and physician-assisted suicide is also authorised in the legislation with strict due care requirements: the patient must be suffering suffering that is incurable in nature and with no medically realistic chance of reversal; the request should be voluntary, thoughtful and persevering; the patient should be fully informed of the diagnosis and prognosis and;⁴⁵ an independent second medical opinion should have been obtained and the manner of death should be within In 2023, 9,068 cases were contacted, which constitute about five per cent of the entire Dutch deaths.⁴⁶

7.2 Belgium

In 2002 Belgium passed its Act on Euthanasia, in which physicians are now allowed to administer euthanasia to patients who are in unbearable physical or mental distress and whose request is voluntary, deliberate and repeated and as a result of a serious and incurable condition, even psychiatric disorder. A 2014 legislative change to allow eligibility of minors without a statutory minimum age, with supplementary procedural protections, is one successful development that has generated much comparative scholarly discussion and stands as one of the most disagreed areas in the regulatory regime of Belgium.⁴⁷

7.3 Switzerland

The Swiss model is structurally unique: whereas direct euthanasia, i.e. when the physician delivers the lethal substance, is an illegal act, assisted suicide, i.e. when a physician offers the means, but the act is taken by the patient is not criminalised, regardless of whether he or she is driven by self-interest. The legislative loophole has allowed organisations like Dignitas and Exit to provide assisted dying to them. The ensuing phenomenon of death tourism - people moving to Switzerland to jurisdictions which have more conservative laws - has spawned continual issues concerning

the fairness of the regulations and the sufficiency of protective measures.⁴⁸

7.4 Canada

The constitutional development of Canada on this issue has been one of the most dramatic in the world. The Supreme Court of Canada did not disagree to find that the ban on physician-aided dying infringed on both Section 7 (life, liberty and security of the person) and Section 15 (equality) of the Canadian Charter of Rights and Freedoms, a unanimous decision on July 23, 2015, in *Carter v. Canada (Attorney General)* (2015).⁴⁹ The reply was found in Bill C-14 (2016) that introduced the Medical Assistance in Dying (MAID) system, later enlarged by Bill C-7 (2021). The operative standard does not merely allow both euthanasia and assisted dying, but makes the applicant, that is (and I suppose ought to be made), to have an admirable and incurable condition likely to cause permanent and intolerable sufferings; the point as to whether applicability should be limited to mental illness, only, is a matter of current legislative consideration.⁵⁰

7.5 United Kingdom

Under the law of England and Wales, both euthanasia and assisted suicide attract criminal liability. However, the courts, especially in *Airedale NHS Trust v. Bland* (1993)⁵¹, have ruled the decision to withdraw artificial nutrition and hydration of a patient in a persistent vegetative condition is a legally and medically justified finding, it does not relate to the statutory definition of unlawful homicide.⁵² A case in point is the Bland ruling, which was directly referred to in Harish Rana as the canonical basis of the CANH reclassification.⁵³

7.6 Comparative Lessons Synthesis.

The comparative survey reveals a global trend of increased legal accommodation of the right to die with dignity by divergent regulatory arrangements. A number of similarities are apparent: the preeminence of human dignity and individual autonomy as basic values of the constitution.; the necessity of procedural protection against abuse; the different treatment of competent and

incapacitated patients; and the urgent necessity of judicial action prior to the response of the legislature. To India, the most educative models are those, especially the Netherlands and Canada, which have established detailed statutory schemes after preliminary judicial acceptance, to deal with the practical implementation gaps unaddressed by judge-made rules.⁵⁴

8. Implementation Challenges in India

8.1 Awareness and Accessibility

The nearest obstacle to the realisation of rights identified in Common Cause and implemented in Harish Rana is the fact that the general population of India do not know almost anything about Advance Directives and the legalisation of passive euthanasia. Information in palliative care organisations have indicated that less than two percent of the terminally ill have implemented some kind of Advance Directive.⁵⁵ The lack of access is further limited by the procedural barrier of the JMFC requirement to attestation, the lack of a standardised Advance Directive form, and the overall inability of government health communication to access patients and families on end-of-life rights. Such a lack is vividly exemplified in the Harish Rana litigation itself: a family which had been giving thirteen years of close personal service was unable to move along the Common Cause protocols on its own, at a time when such protocols were clearly meant to allow administrative redress on a district level.

8.2 Palliative Care Infrastructure Lack.

The right to adequate palliative care cannot be analytically detached to achieve a meaningful right to die with freedom. World Health Organisation describes palliative care as the prevention and alleviation of suffering by early detection, evaluation, and management of pain and the related physical, psychosocial, and spiritual needs.⁵⁶ India is experiencing a terrible structural deficiency in this field: where an estimated number of about 3,000 palliative care service providers are supposed to be, there are currently less than 200 in this country.⁵⁷ The finding of the Harish Rana judgment that withdrawal of treatment must be coupled with a strong, specially designed palliative

and end-of-life care plan has significant normative impact - dignified dying involves active management of pain and other symptoms, rather than the removal of life-sustaining interventions.⁵⁸

8.3 Medical Community Attitudes

The attitude of Indian physicians towards passive euthanasia and Advance Directives is still ambivalent. Research indicates that much of the unease the withdrawal of life-sustaining care can be attributed to a mix of professionally instilled vitalism, legal ambiguity, fear of legal prosecution, and cultural factors that equate death to a failure of the profession.⁵⁹ Following the example of Harish Rana, but since then, with the introduction of a Living Will clinic within Apollo Hospital New Delhi, it appears that the clinical fraternity is starting to take action.⁶⁰

8.4 The Peril of Extraneous Factors: The Warning of the Court Itself.

One of the most notable aspects of Harish Rana as an implementation issue is that the Court took an open-minded view of the fact that in the absence of a complete statutory architecture, withdrawal decisions can be distorted by aspects of the financial depletion of the family, lack of insurance cover, or socio-economic vulnerability which are factors that have absolutely no bearing on a true best interests test but which can systemically affect how both families and the medical

8.5 The Religious and Socio-Cultural Dimensions.

In India, the religious and cultural pluralism poses multifaceted socio-ethical settings in making end-of-life decisions. The Hindu notion of a dignified death (*sumrtyu*), the Islamic notion of life as a trust of God (*amanah*), the antipathy of Christianity to meddling with the divine gift of life, and the Jain practice of self-imposed fasting to death (*sallekhana*) all collide with the legal system in ways that require legislative design to be culturally sensitive.⁶¹ The models of Common Cause and Harish Rana based on secular constitutional principles need to be actualised in

such a way that they do not negate this diversity but ensure the primacy of individual autonomy.

9. Discussion

The jurisprudential tradition leading to Harish Rana (2026) represents the trend which is now observable in most constitutional regimes: apex courts are forced to resolve end-of-life issues in the legislative hiatus generated by parliamentary inaction, gradually building a successive mass of increasingly functional doctrines developing normative force with every successive decision. The three contributions by Harish Rana to the canon of doctrines, that is the unified classification of CANH as medical treatment, the solution to the substantively holistic best interests standard that integrates substituted judgment, and the issue of issuing institutional directions to the governments, echo in the jurisprudential evolution in *Airedale NHS Trust v. Bland* in the United Kingdom, *Carter v. Canada*, and the Dutch regulatory model. The overlap of jurisdiction in regard to the centrality of personal autonomy and dignity indicates that, though not leading, but following world constitutional norms the development of Indian jurisprudence is proceeding along an overall congruent normative path.

However, a key distinguishing aspect which draws a line between India and the Netherlands, Belgium and Canada is that those jurisdictions within ten years of the first judicial acknowledgment sought total statutory codification, pushing the right out past the big-time litigants with the wealth to seek Supreme Court recourse. With, at seven years between legislative actions since *Common Cause*, India has left a constitutional right inaccessible to most of its citizens, the vast majority. The irony of the structure incorporated in Harish Rana speaks volumes: a family that had dedicated 13 years into full-time home based caregiving had to fight before the Supreme Court of India and secure relief which *Common Cause* guidelines had seemingly offered through an administrative process on the district level. This is no judicial failure but is the structural inevitability of a legislative inaction.

The clear recognition the Court made in Harish Rana of the susceptibility of best interests decision-making to external financial pressures is especially noteworthy. In a healthcare system in which most spending is out-of-pocket; and terminal illness may economically ruin families, the potential that withdrawal choices are influenced by economic depletion instead of a true evaluation of patient wellness is not just theoretical. This risk is candidly noted by the Court, and its acceptance that courts alone can effectively respond to it structurally, renders the argument that statutory protections must be enforced far more than merely desirable to fulfill the constitutional requirement.

The general impact of Harish Rana on Indian constitutional law is not only limited to euthanasia. The methodology of its judgment, which systematically uses comparative jurisprudence of seven legal systems, which states a holistic standard of best interests as a constitutional and not simply a clinical norm, and which gives systemic directions to change the infrastructure of the administrative structure, sets a precedent of how the Supreme Court can give operational effect to rights that are in principle but not yet practically available. In this sense, was Harish Rana simply a landmark in the jurisprudential manoeuvre of operationalising rights which exist in constitutional text, but in practice are implausible to the people whose rights they are supposed to safeguard.

10. Limitations

The analysis in this article is attended by several limitations. To begin with, the applied doctrinal methodology albeit suited to legal analysis does not yield empirical data regarding the practical application of both Common Cause and Harish Rana frameworks on the district and hospital level. The practical issues regarding the real frequency of Advance Directive implementation, adherence to the constitution of the Medical Board, and the shift in clinical practice in the aftermath of Harish Rana are still empirically unexplored and would demand individual socio-legal and health systems studies.

Second, the decision of Harish Rana was made on 11 March 2026, and its long-term jurisprudential, legislative and clinical effects cannot be evaluated completely as of the time of writing this article. The guidelines to form Medical Board panels at the district level and administrative guidance to Judicial Magistrates, contained in the judgment, are recent, and their implementation, or lack thereof, in 28 States and 8 Union Territories will take some time to show itself.

Third, the comparative study is limited to five jurisdiction areas, that is, Netherlands, Belgium, Switzerland, Canada, and the United Kingdom which have been chosen due to their influence on Indian jurisprudence in terms of doctrine. The other jurisdictions that have elaborate euthanasia systems, such as Australia, New Zealand, Spain, Colombia and various states in the U.S., are not analyzed in depth. Fourth, the position of minors, persons with psychiatric conditions, or persons in minimally conscious states, which are increasingly debated as to whether they should be included in the eligibility criteria of euthanasia internationally, but remain unaddressed as to whether Indian courts should apply this to minors remains unmentioned in the article.

11. Legislative Recommendations

11.1 Why Parliamentary Action is necessary.

The Common Cause guidelines, published in the year 142, were never meant to be permanent, before the legislation. This call has been rejuvenated and increased by the Harish Rana judgment. The stalemate of the Medical Treatment of Terminally Ill Patients Bill, 2016, and seven years of non-action by the legislature since Common Cause, is a steadily unsustainable constitutional pose.⁶³

11.2 Core Legislative Recommendations

To begin with, the bill ought to institutionalize the right to die with dignity as a legal right based on Article 21, which should be applicable to competent adults who are terminally ill, in incurable coma, or have persistent vegetative state, though in this case, patients with progressive

debilitating conditions should be allowed after a long period of assessment.

Second, the Advance Directive regime would be simplified: the attestation by the JMFC would be replaced with a system that would allow attestation by a Notary Public, Registered Medical Practitioner, or two adult witnesses, and registration in a centralised National Advance Directive Registry (NADR) maintained by the Ministry of Health and Family Welfare.⁶⁴

Third, the bill ought to internalize the Harish Rana best interests standard as a normative statute and clearly stipulate that the financial status, insurance coverage, and socio-economic considerations should be considered legally irrelevant and should not have any impact on the best interests determinations. Fourth, Healthcare Proxy provisions ought to allow individuals to appoint a trusted person to decide on their medical matters in case of loss of capacity to complement the Advance Directive mechanism.

Fourth, the law ought to stipulate the content, processes, and schedules of the Medical Boards of the hospital in conformity with the Harish Rana model. Sixth, medical practitioners that abide by valid Advance Directives or Medical Board recommend that should be given explicit protection against civil and criminal liability. Seventh, palliative care infrastructure needs to be enhanced, with specific amendments to the NDPS Act to ease opioid access to pain management, and the acknowledgement that the right to die with dignity cannot be considered outside the right to live without unmanaged pain.⁶⁵

Fifth, a National End-of-Life Care Commission is necessary, which will have regulatory, monitoring, and reporting roles: creating standardised Advance Directive forms in all scheduled languages; implementing public awareness programmes; releasing annually statistical data on the cases of withdrawing treatment; reviewing the legislation every five years. Professional guidance to medical practitioners should be empowered by the Commission and this should close the gap that exists since the National Medical Commission has

failed to offer such guidance within the current framework.

12. Conclusion

Over thirty years of judicial involvement have formally reshaped the rhetoric of euthanasia in India, which was an illegal topic a matter of law, into a constitutional doctrine which has been formalised and institutionalised. The jurisprudential curve described which runs between P. Rathinam and Gian Kaur, between Common Cause and now Harish Rana, is that of one steady movement, that of a more and more judicial appreciation that the guarantee of Article 21 is not only the right to live in human dignity but also the right to a death in human dignity. Every next decision has perfected and broadened its predecessor, sealing gaps in dogma, and overcoming practical difficulties which, without an abstract constitutional principle, cannot have been overcome.

The case of *Harish Rana v. Union of India* (2026) can be considered a turning point in this direction. This was the first instance when the Supreme Court ordered the physical withdrawal of life-sustaining treatment of an identified person in the Common Cause framework that proved that the constitutional right to die with dignity exists not only as a theory but also as an operationally feasible concept. Its three significant contributions to doctrine, the ultimate categorization of CANH as medical care, the substantive development of a holistic best interests standard that includes substituted judgment, and the systemic orientations necessary to establish the institutional infrastructure needed to have the framework operate, are major contributions to the jurisprudence and overcomes the constraints found in the previous landscape.

But there is also judicial self-criticism in the judgment of a lasting judicial interest. The fact that the family of Harish Rana, who had invested thirteen years and depleted their personal resources in taking care of him, had to go to the Supreme Court before they could get what the Common Cause guidelines in theory allowed them to obtain by an administrative process at the

district level is a sobering indicator of how much still remains to be gained by the framework itself. The Parliament of India has a constitutional responsibility to take action. Meanwhile the medical community, civil society and legal profession have a collective duty to spread information about the rights that have already

been established, to promote easy access to palliative care and develop a culture of end-of-life care, which is informed by the constitutional values of autonomy, dignity and compassion, where every individual, regardless of wealth, geography or social status, will be able to die in the manner he/she would have liked to live.

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