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WITHHOLDING AND WITHDRAWAL OF LIFE-SUSTAINING TREATMENT IN INDIA: RECONCILING PATIENT AUTONOMY, BEST INTERESTS AND THE RIGHT TO DIE WITH DIGNITY

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ABSTRACT

Advances in medical technology have transformed the legal and ethical meaning of death and dying Mechanical ventilation, dialysis, clinically assisted nutrition and hydration (CANH), vasopressors and other life-sustaining interventions can preserve physiological functions for prolonged periods even when the underlying medical condition is irreversible The resulting legal question is therefore not merely whether biological life can be prolonged, but whether a particular medical intervention should continue when it no longer provides a realistic therapeutic benefit or is inconsistent with the patient's wishes, welfare or dignity Indian constitutional jurisprudence has gradually developed a framework for addressing this question P Rathinam v Union of India initially adopted an expansive interpretation of Article 21 by recognising a right to die, but this approach was rejected by the Constitution Bench in Gian Kaur v State of Punjab. At the same time, Gian Kaur recognised the constitutional significance of dignity at the end of natural life Aruna Ramachandra Shanbaug v Union of India subsequently considered withdrawal of life-sustaining treatment from a patient in a persistent vegetative state In Common Cause (A Regd Society) v Union of India, the Constitution Bench recognised the right to die with dignity as part of Article 21 and upheld the validity of Advance Medical Directives (AMDs). The procedural framework was subsequently modified in 2023 to make its implementation more workable.

The Supreme Court's decision in Harish Rana v Union of India, represents an important contemporary development The Court considered clinically assisted nutrition and hydration administered through a medically implanted device as medical treatment capable of being withdrawn within the applicable legal framework The Court also clarified that the best-interests inquiry concerns whether prolonging life through the particular treatment remains in the patient's best interests, rather than whether death itself is beneficial The judgment

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emphasised medical and non-medical considerations, prior wishes and values, the balance-sheet approach, medical-board assessment and continuity of palliative care This article argues that Indian law should increasingly adopt the more precise terminology of withholding and withdrawal of life-sustaining treatment rather than treating all such decisions under the broad expression "passive euthanasia" It proposes a four-stage patient-centred framework based on: (i) present decision-making capacity and wishes; (ii) valid and applicable Advance Medical Directives; (iii) structured best-interests assessment informed by prior wishes and values; and (iv) independent review where disagreement, coercion or substantial uncertainty exists

A comparative examination of the United Kingdom, United States, Netherlands, Canada and Switzerland demonstrates that there is no single international model for end-of-life decision-making These jurisdictions differ significantly in their treatment of refusal of treatment, advance directives, physician-assisted dying, euthanasia, best interests and judicial oversight The comparative lesson for India is therefore not to copy any particular foreign model, but to identify institutional safeguards capable of protecting autonomy while preventing coercion and abandonment The article concludes that India requires comprehensive legislation governing Advance Medical Directives, informed refusal, withholding and withdrawal of life-sustaining treatment, CANH, medical boards, palliative care, professional responsibility and dispute resolution.

Keywords: *Article 21; Right to Die with Dignity; Life-Sustaining Treatment; Withdrawal of Treatment; Patient Autonomy; Best Interests; Advance Medical Directive; CANH; Palliative Care; Euthanasia.*

INTRODUCTION

The impact of modern medicine on the nature of disease, treatment and mortality is very revolutionary. Concerns with sustaining respiratory, circulatory, renal and nutritional supports afforded by technology can preserve a physiological life for extended periods of time. Mechanical ventilation can keep the breathing function alive; dialysis can replace renal function; medicines can help to maintain cardiovascular activity and clinically-assisted nutrition and hydration can keep patients hydrated and nourished when they are unable to do so for themselves.

In numerous situations these interventions are life-sustaining and essential. They can give a short-term solution to recovery, they can stop the needless dying or they can greatly enhance a person's quality of life. When the underlying medical condition becomes terminal, but further

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treatment does not offer a realistic possibility of attaining a therapeutic objective which is valued by the patient, the legal difficulty comes in. So the question of whether or not to cause death is not always the main one It is whether a given medical action continues or not.

Withholding Treatment: When an intervention is not begun. Withdrawal takes place when treatment is stopped that is currently being administered. The reason for either decision can be because of a patient's competent refusal to treatment, due to a valid Advance Medical Directive or if continued treatment is not in the best interests of an incapacitated patient.

These decisions are NOT the same as those that are "deliberately made" with the intent of causing death The difference is of essential importance in building an adequate legal structure. These have been taking care of by a gradual response in Indian constitutional law In P Rathinam v Union of India[1], the Supreme Court took a broad interpretation of Article 21. The Constitution Bench then did not appreciate that there was a general right to die in Gian Kaur, but noted a right to dignity at the end of natural life[2].

Aruna Ramachandra Shanbaug is a case in which the Supreme Court discussed the withdrawal of life sustainer from a person who cannot make a decision at the time of the event Court identified difference between active and passive euthanasia and formulated measures without legislation[3] Following this, the Law Commission of India used in its Report (No 241)[4] reviewed the argument and suggested a statutory provision in certain conditions for a withdrawal and withdrawal of various types of medical care. While the passive euthanasia is embraced by several statements, including the statements by the Catarina Committee, no legislation to that effect has been enacted so far.

The Constitution Bench in Common Cause later defined the notion of "right to die with dignity" under Article 21 of the Constitution, and confirmed the validity of Advance Medical Directives.[5] In 2023, the Common Cause framework was revised to render the procedure practically feasible.[6]

The recent key development is the Supreme Court judgement in Harish Rana vs Union of India It was a case of a patient in a permanent vegetative state for over thirteen years subsequent a severe traumatic brain injury, whose life was supported with physiological maintenance using

[1] P Rathinam v Union of India, AIR 1994 SC 1844 (India).
[2] *Gian Kaur v. State of Punjab*, (1996) 2 S.C.C. 648, 680–81 (India).
[3] *Aruna Ramachandra Shanbaug v. Union of India*, (2011) 4 S.C.C. 454, 466–75 (India).
[4] Law Comm'n of India, *Rep. No. 241:* Passive Euthanasia—A Relook 41–42 (Aug. 2012), https://lawcommissionofindia.nic.in.
[5] *Common Cause (A Regd. Soc'y) v. Union of India*, (2018) 5 S.C.C. 1 (India).
[6] *Common Cause (A Regd. Soc'y) v. Union of India*, (2023) 14 S.C.C. 131 (India).

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CANH, through the administration of a PEG tube.[7] The Supreme Court's decision in *Harish Rana v Union of India* represents the latest major development. The case concerned a patient who had remained in a permanent vegetative state for more than thirteen years following a severe traumatic brain injury and whose physiological survival was being maintained through CANH administered through a PEG tube.

The judgment is important because it moves the debate beyond the abstract question of whether treatment withdrawal is legally permissible It examines how the decision should actually be made when the patient cannot communicate.

This article argues that Indian law is moving from judicial permission towards patient-centred governance**.** The central issue should be whether the process protects autonomy, dignity and welfare rather than merely whether withdrawal can be legally authorised.

CONCEPTUALISING WITHHOLDING AND WITHDRAWAL OF LIFE-SUSTAINING TREATMENT

A Withholding and Withdrawal

Withholding and withdrawal are two forms of treatment limitation. **Withholding** occurs where treatment is not commenced. For example, a competent patient may refuse mechanical ventilation or clinicians may decide not to initiate an intervention that provides no realistic therapeutic benefit. **Withdrawal** occurs where treatment already being provided is discontinued.[8] Examples include discontinuation of mechanical ventilation, dialysis or CANH following a lawful determination that continuation is inappropriate.[9]

The distinction does not necessarily mean that withdrawal causes death. The treatment is discontinued because it is no longer authorised, beneficial or appropriate. Where death follows, it ordinarily results from the underlying illness or medical condition.

The legal inquiry should therefore consider the patient's decision-making capacity; present wishes; the existence and applicability of an Advance Medical Directive; prior wishes and values; medical condition and prognosis; therapeutic benefit; burdens of treatment; dignity and welfare; availability of palliative care; and compliance with procedural safeguards.

This treatment-focused approach provides greater clarity than categorising every treatment-withdrawal decision as "passive euthanasia".

[7] *Harish Rana v. Union of India*, 2026 INSC 222 (India).
[8] *Common Cause*, (2018) 5 SCC 1, ¶¶ 193–95 (India), *Aruna Ramachandra Shanbaug* (2011) 4 SCC 454, ¶¶ 104–11 (India).
[9] *Harish Rana ,* 2026 INSC 222, ¶¶ 116–28 (India).

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FROM "PASSIVE EUTHANASIA" TO WITHDRAWAL OF MEDICAL TREATMENT

The expression "passive euthanasia" has played an important role in Indian jurisprudence *Aruna Shanbaug* used the active/passive distinction to explain circumstances in which life-sustaining treatment could be withdrawn *Common Cause* subsequently recognised passive euthanasia within a constitutional framework.

Nevertheless, the terminology requires careful reconsideration. Euthanasia generally refers to an intentional act undertaken for the purpose of causing death. Withdrawal of life-sustaining treatment may rest on a fundamentally different legal basis.

Treatment may be withdrawn because:

1. the patient has competently refused it;
2. a valid Advance Medical Directive requires its withdrawal;
3. treatment no longer provides therapeutic benefit;
4. treatment imposes disproportionate burdens;
5. continued treatment is contrary to the patient's best interests; or
6. continuation would violate constitutionally protected autonomy and dignity.

Thus, the legal question is not whether a person should be caused to die It is whether a particular treatment should continue. The expression "passive euthanasia" may therefore be retained as a historical judicial term, but withholding and withdrawal of life-sustaining medical treatment provides a more precise analytical framework.

ARTICLE 21 AND THE RIGHT TO DIE WITH DIGNITY

Article 21 of the Constitution provides:

"No person shall be deprived of his life or personal liberty except according to procedure established by law"[10]

The meaning of "life" under Article 21 has expanded beyond mere biological existence Constitutional jurisprudence has connected Article 21 with dignity, privacy, bodily integrity, personal autonomy and decisional freedom.[11]

The end-of-life debate must therefore be understood within this broader conception of personal liberty. A distinction must nevertheless be maintained between a right to die and a right to die with dignity.

[10] INDIA CONST. art. 21.

[11] *Justice K.S. Puttaswamy (Retd.) v. Union of India, (2017) 10 SCC 1, ¶¶ 298–99; Common Cause, (2018) 5 SCC 1, ¶¶ 188–91.*

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In *P Rathinam*, the Supreme Court interpreted Article 21 as including a right to die.[12] This proposition was rejected by the Constitution Bench in *Gian Kaur*. The Court nevertheless recognised that dignity extends to the natural process of dying.[13]

This distinction remains constitutionally important. A general right to die could be understood as an entitlement to intentionally terminate life. A right to die with dignity concerns the manner in which the natural dying process occurs and the extent to which unwanted medical intervention may be imposed *Common Cause* subsequently recognised the right to die with dignity as part of Article 21 and connected it with personal autonomy and Advance Medical Directives.[14]

The contemporary constitutional position can therefore be stated as follows:

- Article 21 does not create an unrestricted general right to cause one's own death.
- Article 21 protects dignity, bodily integrity and decisional autonomy at the end of life.
- A competent person may, within the law, refuse medical treatment even where refusal may result in death.
- An incapacitated patient's prior autonomous choices may continue to have legal significance through an Advance Medical Directive or other evidence of wishes and values.[15]

The constitutional objective is therefore not to create a right to death but to ensure that biological survival is not treated as the patient's only legally relevant interest.

JUDICIAL EVOLUTION OF END-OF-LIFE LAW IN INDIA

A. *P Rathinam v Union of India*[16]

P Rathinam represented an early and expansive interpretation of Article 21 The Supreme Court held that the right to life included a right to die and examined the constitutionality of Section 309 of the Indian Penal Code

The decision was subsequently overruled by the Constitution Bench in *Gian Kaur* Nevertheless, it initiated an important constitutional conversation concerning personal autonomy and the meaning of life under Article 21

[12] P Rathinam, AIR 1994 SC 1844 (India).
[13] *Gian Kaur*, (1996) 2 S.C.C. 648(India).
[14] C*ommon Cause*, (2018) 5 SCC 1 (India).
[15] *Harish Rana ,* 2026 INSC 222 (India).
[16] P Rathinam, AIR 1994 SC 1844 (India).

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B *Gian Kaur v State of Punjab*[17]

Gian Kaur rejected the proposition that Article 21 contains a general right to die However, the judgment recognised that the right to live with dignity extends to the end of natural life This distinction laid the conceptual foundation for later treatment-withdrawal jurisprudence.

The judgment therefore left space for recognising dignity in the dying process without recognising a general right to intentionally cause death.

C *Aruna Ramachandra Shanbaug v Union of India*[18]

Aruna Shanbaug involved a patient who had remained in a persistent vegetative state for decades. The Supreme Court distinguished active euthanasia from passive euthanasia and permitted withdrawal of life-sustaining treatment subject to safeguards.

Its importance lies in recognising that continued medical intervention is not necessarily mandatory in every circumstance. At the same time, the reliance on judicial safeguards demonstrated the consequences of the absence of comprehensive legislation.

D *Common Cause v Union of India*[19]

The Constitution Bench in *Common Cause* fundamentally changed Indian end-of-life jurisprudence The Court recognised the right to die with dignity as part of Article 21 and recognised Advance Medical Directives as a constitutionally permissible mechanism for exercising autonomy after loss of capacity.

An Advance Medical Directive allows a person, while competent, to communicate preferences concerning future medical treatment in circumstances in which they may subsequently lose decision-making capacity It therefore extends autonomy across time.

E *Common Cause*, 2023 Modification[20]

The procedural framework created in 2018 encountered practical difficulties. In 2023, the Supreme Court modified the framework to make its implementation more workable. The 2023 development is important because constitutional rights require effective procedures. An excessively complicated procedure may render a recognised right practically inaccessible. The modification therefore demonstrates the continuing attempt to balance autonomy with safeguards.

[17] *Gian Kaur*, (1996) 2 S.C.C. 648(India).
[18] *Aruna Ramachandra Shanbaug*, (2011) 4 S.C.C. 454 (India).
[19] *Common Cause*, (2018) 5 SCC 1 (India).
[20] *Common Cause*, (2023) 14 S.C.C. 131 (India).

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HARISH RANA v UNION OF INDIA: THE CONTEMPORARY DEVELOPMENT

The Supreme Court's decision in *Harish Rana v Union of India*[21], 2026 INSC 222, represents an important development in Indian end-of-life jurisprudence.

The case concerned a patient who had remained in a permanent vegetative state for more than thirteen years following severe traumatic brain injury His survival was being maintained through CANH administered through a PEG tube.

The case raised several questions:

- whether CANH constitutes medical treatment?
- how the best-interests principle should operate?
- what medical and non-medical considerations may be considered?
- what role the patient's family should play?
- what role medical boards should play?
- when judicial intervention is necessary? and
- what safeguards should govern withdrawal?

The judgment is significant because it develops the institutional architecture for decision-making where the patient lacks capacity.

CANH AS MEDICAL TREATMENT

One of the central issues in *Harish Rana* was whether clinically assisted nutrition and hydration constitutes medical treatment. The Court recognised that where nutrition and hydration are delivered through medical technology such as a PEG tube, the intervention can constitute medical treatment. Ordinary food and water are basic necessities of life. However, medically administered nutrition and hydration involve medical technology; professional supervision; clinical decisions; monitoring; management of complications; and continuing medical intervention. CANH should therefore not be legally immune from treatment-withdrawal analysis merely because nutrition and hydration are essential to human survival. [22]

This does not mean that CANH should ordinarily be withdrawn. It means that its continuation must be evaluated in the context of the patient's condition, wishes, welfare and treatment objectives.

[21] *Harish Rana,* 2026 INSC 222 (India).
[22] *Id.* ¶¶ 132–33.

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THE BEST-INTERESTS PRINCIPLE AFTER *HARISH RANA*

The most significant contribution of *Harish Rana* is its clarification of the best-interests principle. The relevant question is not whether death itself is in the patient's best interests. The question is whether prolonging life through continuation of the particular medical treatment remains in the patient's best interests.

An inquiry into whether death is beneficial risks turning the legal process into an assessment of the value of a person's life. A treatment-focused inquiry instead asks whether continued medical intervention serves the patient. Best interests therefore require a holistic assessment. Relevant factors may include prognosis; possibility of recovery; therapeutic benefit; invasiveness; treatment burdens; physical suffering; psychological consequences; known wishes; values and beliefs; prior statements; lived experience; family evidence concerning the patient's own preferences; and palliative alternatives. The balance-sheet approach allows benefits and burdens to be considered together rather than reducing the decision to one medical factor.[23]

AUTONOMY, PRIOR WISHES AND SUBSTITUTED JUDGMENT

When the patient has capacity, their informed and voluntary decision should ordinarily control. When capacity is lost, a valid Advance Medical Directive may provide direct evidence of the patient's autonomous wishes. Where no formal directive exists, prior statements, beliefs, values and conduct may help determine what the patient would have wanted. This resembles the doctrine of substituted judgment.

However, substituted judgment and best interests are not identical. **Substituted judgment** asks, 'What would this patient have decided if they retained capacity?' whereas **best interests** ask for 'What decision now serves this patient's welfare and interests?' The two approaches overlap but cannot simply be equated.

The emerging Indian approach can therefore be understood as:

Present autonomy → Advance Medical Directive → prior wishes and values → structured best interests → independent review where necessary.

This hierarchy provides stronger protection than either absolute medical paternalism or unrestricted substituted decision-making.

[23] *Id.* ¶¶ 132–33, 234–39..

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THE ROLE OF FAMILY MEMBERS

Family participation is important because relatives may possess information about the patient's values; previous statements; attitudes toward medical intervention; religious or philosophical beliefs; tolerance for dependency; quality-of-life preferences; and previous healthcare decisions

However, family members should not acquire ownership of the patient's constitutional rights A relative's financial, emotional or caregiving interests cannot independently determine whether treatment should be withdrawn Family evidence should therefore be relevant primarily insofar as it assists in determining the patient's wishes, values and welfare The patient's interests must remain central.[24]

MEDICAL BOARDS AND INDEPENDENT SAFEGUARDS

Medical prognosis often requires specialised expertise Determining whether a neurological condition is irreversible or whether treatment provides therapeutic benefit cannot ordinarily be answered by legal reasoning alone.

Medical boards therefore serve an important institutional function. The *Common Cause* framework relies on medical-board assessment. *Harish Rana* further demonstrates that where medical boards reach a consistent conclusion and the applicable procedural requirements have been satisfied, routine judicial intervention may not be necessary. Courts are not normally the appropriate institutions for making detailed clinical determinations.

Judicial or independent review should nevertheless remain available where medical boards disagree; an Advance Medical Directive is disputed; coercion is alleged; the patient's wishes are contested; medical evidence is substantially uncertain; conflicts of interest exist; or constitutional or procedural violations are alleged. The ideal model is therefore medical expertise combined with legal accountability.[25]

PALLIATIVE CARE AND CONTINUITY OF CARE

Withdrawal of life-sustaining treatment must never mean withdrawal of care When ventilation, dialysis, CANH or another intervention is lawfully withdrawn, the patient's entitlement to appropriate medical and palliative care continues. Palliative care may include pain management; relief of respiratory distress; symptom control; psychological support; emotional

[24] *Id.* ¶¶ 234–262.
[25] *Id.* ¶ 225-325.

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support; and family counselling.

The legal system should distinguish clearly between withdrawal of a particular treatment, and withdrawal of care itself. The former may be lawful. The latter may constitute abandonment. Any Indian statutory framework should therefore require an appropriate palliative-care plan alongside a lawful treatment-withdrawal decision.

DIGNITY, DISABILITY AND THE VALUE OF LIFE[26]

End-of-life law must remain sensitive to disability rights Dependence upon others does not establish that a person's life lacks value Similarly, inability to communicate does not automatically establish absence of consciousness, interests or preferences. The principle should therefore be ‘Dependence is not indignity, and disability is not futility’.

The best-interests inquiry must focus upon the patient's actual medical circumstances and values rather than assumptions about disability A patient should not be considered a candidate for treatment withdrawal merely because they cannot walk, speak, eat independently or communicate. The relevant questions are whether the condition is irreversible, what the treatment achieves, what burdens it imposes and what the patient would have wanted.

ECONOMIC PRESSURE AND VULNERABILITY[27]

Economic pressure presents another serious concern Long-term treatment can impose substantial costs upon patients, families and healthcare institutions However, financial burden must not become an indirect mechanism for determining whose life should continue.

A distinction must therefore be maintained between a treatment being medically inappropriate, and a treatment being unaffordable. These are fundamentally different questions. If treatment is medically appropriate but unaffordable, the appropriate response may involve public healthcare, insurance, social assistance or institutional support. Economic disadvantage should never by itself become a reason for withdrawal of treatment.

COMPARATIVE PERSPECTIVE

The development of Indian end-of-life law becomes clearer when examined alongside other jurisdictions The United Kingdom, United States, Netherlands, Canada and Switzerland have developed substantially different approaches to treatment refusal, withdrawal, advance

[26] See *Common Cause*, (2018) 5 SCC 1, ¶¶ 194–95.
[27] *Id.*; *Harish Rana*, 2026 INSC 222, ¶¶ 132–33.

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directives, euthanasia and assisted dying

The comparison demonstrates that end-of-life law has two distinct dimensions:

1. decisions concerning refusal or withdrawal of medical treatment; and
2. deliberate assistance in causing death

These should not be conflated.

A United Kingdom

The United Kingdom provides an important comparison because its law strongly recognises the autonomy of competent patients and uses a best-interests framework for persons lacking capacity. The landmark decision in *Airedale NHS Trust v Bland*[28] accepted that life-sustaining treatment could, in appropriate circumstances, be withdrawn from a patient in a persistent vegetative state.

The Mental Capacity Act 2005[29]subsequently established a statutory framework for decision-making concerning persons who lack capacity. The best-interests assessment requires consideration of the person's wishes, feelings, beliefs and values together with other relevant circumstances.

UK jurisprudence therefore provides an important conceptual foundation for India's developing best-interests approach.

The lesson for India is particularly relevant where best interests should not be equated with what doctors or relatives consider desirable; it must remain a patient-centred assessment. At the same time, the UK does not generally permit euthanasia or physician-assisted suicide. Thus, the UK illustrates that recognition of treatment refusal and withdrawal does not necessarily require legalisation of active euthanasia.

B United States

The United States places considerable emphasis on constitutional and common-law protection of bodily autonomy and informed consent

The landmark case *Cruzan v Director, Missouri Department of Health* [30]recognised that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment. The case also demonstrated the evidentiary difficulties involved when an incapacitated patient has not left sufficiently clear instructions Advance directives and

[28] *Airedale NHS Trust v. Bland*, [1993] A.C. 789, 817–22 (H.L.).
[29] Mental Capacity Act 2005, c. 9, § 1, 4 (UK).
[30] *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 278–80 (1990).

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healthcare proxies have consequently become important mechanisms for communicating patient preferences.

The American approach is significant for India because it demonstrates the practical importance of advance planning. A constitutional right to refuse treatment becomes difficult to exercise after incapacity unless legal mechanisms exist to establish the patient's wishes. The United States also illustrates the distinction between treatment withdrawal and physician-assisted dying. The legality of physician-assisted dying varies by state, while withdrawal of unwanted medical treatment rests on a separate legal foundation.

The Indian lesson is therefore that treatment refusal and assisted dying should remain analytically distinct, while advance directives and surrogate decision-making require clear statutory rules.

C Netherlands

The Netherlands represents a substantially different model Dutch law permits euthanasia and physician-assisted suicide under strict statutory conditions established by the Termination of Life on Request and Assisted Suicide Act.[31]

The Dutch framework therefore goes beyond the Indian model of withholding or withdrawing life-sustaining treatment. However, the Dutch system remains highly regulated Physicians must comply with statutory due-care requirements, including requirements concerning a voluntary and well-considered request, unbearable suffering without prospect of improvement, informed decision-making and appropriate consultation. The Netherlands therefore demonstrates that where a legal system permits intentional assistance in dying, strong procedural safeguards become essential.[32]

For India, the principal comparative lesson is not that euthanasia should be adopted Rather, the Dutch experience demonstrates the importance of clear statutory definitions, professional duties, independent consultation and reporting mechanisms whenever end-of-life decisions involve exceptional legal consequences.

D Canada

Canada provides another important model because it combines recognition of treatment autonomy with a statutory framework for medical assistance in dying (MAID). Canadian law recognises a patient's right to refuse medical treatment and has also established a regulated

[31] Termination of Life on Request and Assisted Suicide (Review Procedures) Act (Neth.).
[32] Id.

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system for medical assistance in dying under federal legislation.[33]

The Canadian framework is therefore broader than India's current treatment-withdrawal model. The Canadian experience is particularly relevant to the relationship between autonomy and safeguards. Medical assistance in dying is subject to eligibility criteria and procedural requirements, while treatment withdrawal remains conceptually distinct.

Canada therefore demonstrates that a sophisticated end-of-life framework can distinguish among refusal of treatment; withdrawal of life-sustaining treatment; palliative care; and medical assistance in dying. This conceptual separation is valuable for India.

E Switzerland

Swiss law permits assisted suicide under particular conditions, while active euthanasia remains prohibited The Switzerland presents another distinctive model Swiss law permits assisted suicide under particular conditions, while active euthanasia remains prohibited The legal framework therefore distinguishes between assistance in suicide and directly causing death.

Switzerland's experience is especially relevant to the question of institutional safeguards and professional involvement The Swiss model demonstrates that legal systems can recognise a degree of individual autonomy concerning the end of life without treating all forms of assistance in dying as legally equivalent.

For India, the principal lesson is the importance of maintaining clear distinctions between refusal of treatment, withdrawal of treatment, assisted suicide and euthanasia.

F Comparative Lessons for India

The comparison demonstrates that there is no universal model

Jurisdiction	**Treatment refusal/withdrawal**	**Advance directives**	**Assisted dying /euthanasia**	**Main lesson for India**
India	Constitutionally recognised within judicial safeguards	Recognised under *Common Cause*	No general legalised euthanasia/assisted dying framework	Need comprehensive legislation
UK	Strongly recognised	Statutory framework	Generally prohibited	Patient-centred best interests

[33] Criminal Code, R.S.C. 1985, c. C-46, §§ 241.1–241.2 (Can.).

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USA	Strong autonomy-based protection	Widely used	Varies by state	Importance of advance planning and surrogate decision-making
Netherlands	Recognised separately from euthanasia	Recognised	Euthanasia/assisted suicide permitted under strict conditions	Clear statutory safeguards
Canada	Recognised	Statutory framework	MAID permitted under federal law subject to safeguards	Clear separation of treatment withdrawal and assisted dying
Switzerland	Treatment refusal recognised	Recognised	Assisted suicide permitted under particular conditions; active euthanasia prohibited	Distinguish assisted dying from treatment withdrawal

The most important comparative conclusion is that India need not adopt the euthanasia models of the Netherlands, Canada or Switzerland in order to develop a sophisticated law of treatment withdrawal.

The UK and US experience demonstrates the importance of autonomy and advance planning The Netherlands, Canada and Switzerland demonstrate the importance of precise statutory distinctions and procedural safeguards where end-of-life decisions may result in death.

The Indian framework should therefore selectively borrow institutional safeguards, not simply foreign substantive rules.

FROM JUDICIAL PERMISSION TO PATIENT-CENTRED GOVERNANCE

Indian jurisprudence can be understood through three broad stages.

First Stage: Judicial Permission

Aruna Shanbaug established that withdrawal of life-sustaining treatment could be legally permissible under controlled circumstances.

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Second Stage: Constitutional Recognition

Common Cause transformed the framework by recognising the right to die with dignity and validating Advance Medical Directives.

Third Stage: Institutionalised Decision-Making

Harish Rana develops the institutional framework by addressing CANH, best interests, medical boards, family participation and palliative care.

The central question is therefore no longer merely, 'Is treatment withdrawal legally permissible?' It is 'What decision-making process most faithfully protects the patient's autonomy, dignity and welfare when the patient cannot speak for themselves?' That should be the central question for future legislation.

A FOUR-STAGE PATIENT-CENTRED MODEL FOR INDIA

This model is being provided by this article.

Stage One: Present Capacity and Wishes

The first question should always be whether the patient possesses decision-making capacity Where capacity exists, an informed and voluntary treatment decision should ordinarily govern.

Stage Two: Advance Medical Directive

Where the patient lacks capacity, the institution should determine whether a valid and applicable Advance Medical Directive exists. The directive should be authentic; voluntary; executed while the patient possessed capacity; sufficiently clear; applicable to the present circumstances; and free from coercion or fraud.

Stage Three: Structured Best Interests

Where no applicable directive exists, a structured best-interests assessment should be undertaken Relevant considerations should include medical prognosis; possibility of recovery; therapeutic benefit; treatment burdens; invasiveness; physical and psychological consequences; prior statements; values and beliefs; family evidence concerning the patient's wishes; disability-related considerations; palliative alternatives; and overall welfare The question should remain as 'Is continuation of this particular treatment in the patient's best interests?'

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Stage Four: Independent Review

Independent review should be available where medical boards disagree; an Advance Medical Directive is disputed; coercion is alleged; the patient's wishes are seriously contested; conflicts of interest exist; medical evidence is substantially uncertain; or a significant legal issue arises This framework combines medical expertise with legal accountability without requiring routine judicial intervention.

PROPOSED LEGISLATIVE REFORMS

India requires comprehensive legislation governing end-of-life treatment. Such legislation should provide for the following.

1 Statutory recognition of informed refusal

A competent adult should have an express legal right to refuse medical treatment, subject to capacity, voluntariness and informed decision-making

2 Accessible Advance Medical Directives

The process of creating an AMD should be simple, affordable and accessible

3 Reliable registration

An interoperable national or state-level registry should enable hospitals to determine whether an AMD exists

4 Clearly defined medical boards

Legislation should establish qualifications, composition, independence, responsibilities and procedures for Primary and Secondary Medical Boards

5 Express recognition of CANH

Medically administered nutrition and hydration should be expressly addressed as potentially constituting life-sustaining treatment

6 Mandatory palliative-care planning

Every lawful treatment-withdrawal decision should include an appropriate palliative-care plan

7 Protection against coercion

The law should require consideration of financial, familial, institutional and other pressures

8 Disability protection

Disability, dependence, age or inability to communicate should never independently justify treatment withdrawal

9 Professional protection

Healthcare professionals acting in good faith and in compliance with the statutory framework should receive appropriate legal protection, while remaining accountable for negligence, bad

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faith and misconduct

10 Expedited dispute resolution

Disputes should be resolved quickly because prolonged proceedings may themselves defeat the purpose of dignified end-of-life care.

CRITICAL ANALYSIS

The Supreme Court's jurisprudence represents a major constitutional development. Recognition of dignity prevents biological survival from becoming the exclusive measure of lawful medical treatment and recognition of Advance Medical Directives permits autonomy to continue beyond the point of incapacity

The 2023 *Common Cause* development attempted to make the framework practically workable *Harish Rana* adds a further layer by clarifying CANH and developing the best-interests analysis. Its most important contribution is the reframing of the legal question

The Court does not ask, 'Is it in the patient's best interests to die?' but it asks 'whether continued life through the particular medical treatment remains in the patient's best interests?' This formulation reduces the danger of abstract judgments concerning the value of human life

Nevertheless, significant problems remain:

First, absence of comprehensive legislation.

The framework continues to depend heavily on judicially created procedures

Second, uncertainty in best-interests decisions.

Where no AMD exists, different decision-makers may interpret similar evidence differently.

Third, institutional inequality.

Healthcare institutions may differ substantially in their medical-board and palliative-care capacity.

Fourth, family pressure.

Family participation is valuable but can be affected by financial and emotional pressures.

Fifth, limited palliative infrastructure.

Treatment withdrawal without adequate palliative support risks becoming abandonment.

Sixth, disability concerns.

The law must ensure that disability and dependence are not mistaken for lack of dignity.

Seventh, lack of clarity concerning substituted judgment.

Legislation should clarify the relationship between prior wishes and objective best interests.

Thus, *Harish Rana* is an important development but also demonstrates the limits of judicial law-making.

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WHY COMPREHENSIVE LEGISLATION IS NECESSARY

The Supreme Court has developed end-of-life jurisprudence substantially because Parliament has not enacted comprehensive legislation Judicial development has been constitutionally valuable but cannot provide a complete national framework.

Legislation is required to establish uniform standards concerning capacity; informed refusal; Advance Medical Directives; withholding; withdrawal; CANH; medical boards; family participation; substituted judgment; best interests; palliative care; professional liability; coercion; disability protection; and dispute resolution. The objective should not merely be to codify "passive euthanasia" India requires a comprehensive law of treatment limitation at the end of life.

THE PROPOSED LEGAL HIERARCHY

The central normative proposal of this article can be expressed as follows:

1 Present autonomy

Where the patient has capacity, their informed and voluntary decision should ordinarily govern

2 Prior autonomy

Where capacity is lost, a valid and applicable Advance Medical Directive should ordinarily be respected

3 Reconstruction of preferences

Where no formal directive exists, prior statements, values, beliefs and conduct should inform the decision

4 Structured best interests

Where the patient's wishes cannot reliably be established, a holistic best-interests assessment should govern

5 Independent review

Where disagreement, coercion or substantial uncertainty exists, independent review should be available

This hierarchy reconciles autonomy with protection. It avoids both unrestricted medical paternalism and unregulated decision-making on behalf of vulnerable persons.

PRESERVING LIFE AND PROLONGING TREATMENT

A crucial insight from the emerging jurisprudence is that preserving life and continuing medical treatment are not necessarily identical objectives A treatment may preserve physiological

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function without restoring consciousness, reversing the underlying disease or achieving an outcome valued by the patient This does not automatically make treatment inappropriate It means that the purpose and consequences of continued intervention must be examined. The relevant question is therefore not, 'Can medicine continue to sustain biological life?' The more important question is 'Should this particular treatment continue for this particular patient under these particular circumstances?' This patient-specific inquiry is more compatible with constitutional dignity than a universal rule requiring maximum technological intervention

PATIENT-CENTRED GOVERNANCE

End-of-life law should not be framed simply as a conflict between the sanctity of life and the right to die That binary is inadequate.

The actual legal problem involves multiple values preservation of life; autonomy; dignity; bodily integrity; medical professionalism; family participation; disability rights; prevention of coercion; palliative care; and institutional accountability.

Patient-centred governance provides a framework capable of reconciling these values It does not diminish the sanctity of life. Rather, it recognises that respect for life includes respect for the person whose life is being medically sustained. Likewise, autonomy does not mean that treatment must be withdrawn whenever relatives request it. The decision must remain structured, evidence-based and centred upon the patient.

CONCLUSION

Indian end-of-life jurisprudence has undergone a significant transformation The constitutional debate initially concerned whether the right to life includes a right to die *P Rathinam* adopted an expansive approach, which was rejected by the Constitution Bench in *Gian Kaur* Yet *Gian Kaur* preserved the constitutional significance of dignity at the end of natural life *Aruna Shanbaug* subsequently established that withdrawal of life-sustaining treatment could be legally permissible under safeguards *Common Cause* marked a major constitutional development by recognising the right to die with dignity under Article 21 and validating Advance Medical Directives The 2023 modification sought to make the framework more practical.

Harish Rana represents the next stage The Supreme Court has clarified that CANH administered through medical technology may constitute medical treatment capable of being considered for withdrawal More importantly, the Court has developed the best-interests inquiry

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by directing attention to whether continuation of the particular treatment remains in the patient's best interests rather than whether death itself is beneficial The comparative experience of the United Kingdom, United States, Netherlands, Canada and Switzerland demonstrates that no single foreign model provides a complete solution for India.

The United Kingdom demonstrates the importance of a structured best-interests framework. The United States illustrates the importance of advance directives and surrogate decision-making. The Netherlands demonstrates the value of precise statutory safeguards where euthanasia is legally permitted. Canada demonstrates the importance of distinguishing treatment withdrawal from medical assistance in dying within a comprehensive statutory system Switzerland demonstrates the importance of maintaining clear distinctions between assisted suicide and active euthanasia.

India should therefore borrow principles and institutional safeguards rather than foreign models wholesale. The emerging Indian hierarchy should be present autonomy where capacity exists; prior wishes through a valid Advance Medical Directive where capacity is absent; structured best interests where wishes cannot reliably be established; and independent review where significant disagreement or uncertainty remains.

This framework protects autonomy without abandoning vulnerable patients It recognises that a patient who loses capacity does not lose personhood It recognises that family members are important participants but do not acquire ownership of the patient's constitutional rights It recognises that medical boards provide necessary expertise but must remain subject to institutional and legal safeguards It recognises that withdrawal of a life-sustaining treatment is not withdrawal of care It recognises that palliative care must accompany lawful treatment limitation It recognises that disability, dependence and inability to communicate cannot by themselves establish that a person's life is undignified or medically futile.

Most importantly, the law should not ask whether a patient's life is worth living,

The proper question is, ‘Whether, in light of the patient's wishes, values, medical condition, welfare, and the benefits and burdens of treatment, continuation of the particular life-sustaining intervention remains justified’

The jurisprudence nevertheless demonstrates the limits of judicial law-making The Supreme Court has repeatedly had to create and modify procedures because comprehensive legislation has not been enacted India therefore requires comprehensive legislation governing Advance Medical Directives, informed refusal, withholding and withdrawal of life-sustaining treatment, CANH, medical boards, palliative care, professional responsibility and dispute resolution Such legislation should not reduce end-of-life law to a choice between life and death.

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Its objective should be more precise as to ensure that the patient remains at the centre of medical decision-making even when the patient can no longer speak.

The constitutional promise of dignity does not disappear with incapacity Nor does dependence upon medical technology make a person less worthy of legal protection The purpose of end-of-life law should therefore be neither to prolong biological existence at all costs nor to facilitate death merely because treatment has become burdensome Its purpose should be to establish a lawful, transparent, compassionate and patient-centred framework in which autonomy, dignity and welfare continue to guide medical decisions until the natural end of life.