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DIGNITY AT THE THRESHOLD OF DEATH: PASSIVE EUTHANASIA, ADVANCE MEDICAL DIRECTIVES AND THE EVOLVING CONSTITUTIONAL JURISPRUDENCE OF THE RIGHT TO DIE WITH DIGNITY IN INDIA

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Abstract

Passive euthanasia, the lawful withholding or withdrawal of life-sustaining treatment, sits between the constitutional guarantee of life and personal liberty under Article 21 and the criminal law's ban on intentionally hastening death. This article traces the Indian judicial path from *Gian Kaur* (1996) and *Aruna Shanbaug* (2011) through *Common Cause* (2018), its 2023 procedural modification, and *Harish Rana v. Union of India* (2026). In *Harish Rana*, the Supreme Court for the first time applied the framework in full and permitted withdrawal of clinically assisted nutrition and hydration from a patient in a permanent vegetative state. Using doctrinal and comparative methods, the article argues that Indian law has moved from recognising a right to die with dignity in principle to operationalising it in practice, yet the machinery still rests on judge-made guidelines rather than legislation. Three problems remain unresolved: the reach and evidentiary discipline of the "best interests" standard for patients without an advance directive; the tension between dignity-based reasoning and disability rights; and the lack of palliative-care infrastructure and statutory protection for practitioners. The article closes by proposing the core elements of a comprehensive end-of-life care statute.

Keywords: passive euthanasia; Article 21; right to die with dignity; advance medical directive; best interests; clinically assisted nutrition and hydration; palliative care; India.

1. Introduction

Few questions test a constitutional order as severely as the question of who may decide that a life should no longer be prolonged by machines. Modern critical care can sustain breathing, circulation and nourishment long after the capacity for awareness has been lost. Criminal law, by contrast, took shape in an age when death followed illness rather than being deferred by technology, and it has struggled to describe a physician's decision to stop treatment in any

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vocabulary other than homicide or abetment of suicide.

India's response has been led almost entirely by the judiciary. Beginning with *Gian Kaur v. State of Punjab* (1996) 2 SCC 648, the Supreme Court separated a right to life from any right to extinguish life, while leaving room for the idea that dying with dignity may form part of living with dignity. A Constitution Bench in *Common Cause v. Union of India* (2018) 5 SCC 1 then held that the right to die with dignity is part of Article 21, recognised advance medical directives, and laid down guidelines for withdrawal of treatment. A second Constitution Bench eased those guidelines in January 2023. Yet the framework remained largely untested in practice. That changed on 11 March 2026, when a two-judge Bench in *Harish Rana v. Union of India* (2026 INSC 222) applied the framework in its full measure and permitted withdrawal of clinically assisted nutrition and hydration (CANH) from a man who had been in a permanent vegetative state for over thirteen years.

This article examines that trajectory and its present consequences. It asks three questions:

1. How has Indian jurisprudence on passive euthanasia evolved, and which doctrinal principles now govern it?
2. What did *Harish Rana* add to *Common Cause*, particularly on the legal character of CANH and on the interplay between "best interests" and substituted judgment?
3. What legislative, ethical and institutional gaps remain, and how might they be closed?

The study is doctrinal. It analyses primary sources (judgments, statutory provisions, Law Commission reports and executive guidance) and reads them against comparative authority from the United Kingdom, the United States and other jurisdictions, together with recent scholarly commentary available up to September 2026. The scope is deliberately limited. The article concerns passive euthanasia only; active euthanasia and assisted dying remain unlawful in India and are discussed solely for contrast.

The argument proceeds in eight steps. Part 2 fixes the conceptual vocabulary. Parts 3 and 4 follow the judicial evolution up to the 2023 modification. Part 5 analyses the most recent developments. Part 6 draws comparative lessons. Part 7 offers a critical assessment, Part 8 sets out recommendations, and Part 9 concludes.

2. Conceptual and Statutory Framework

Euthanasia denotes a deliberate act or omission that brings life to an end in order to relieve suffering. The literature sorts it along two axes. The first is the patient's consent: voluntary (the competent patient asks), non-voluntary (the patient cannot express a wish) and involuntary (the patient's wish is overridden). The second is the means: an act that causes death (active) or a

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decision not to start, or to stop, treatment that is prolonging life (passive). Indian courts have adopted the second axis as their organising distinction, permitting the passive form under strict safeguards and rejecting the active form pending legislation.

Concept	Core feature	Position in Indian law
Active euthanasia	A positive act, such as administering a lethal drug, that ends life	Not permitted; held to require legislation (*Aruna Shanbaug*, 2011; reaffirmed in *Common Cause*, 2018)
Physician-assisted suicide	The patient ends life with means supplied by another	Not permitted; assistance falls within abetment of suicide (*Gian Kaur*, 1996)
Passive euthanasia	Withholding or withdrawing life-sustaining treatment so that death follows the underlying condition	Permitted under judicially framed guidelines (*Common Cause*, 2018; modified 2023; applied in *Harish Rana*, 2026)
Advance medical directive	A competent adult's written instruction on future treatment refusal	Recognised in *Common Cause*; procedure simplified in 2023
Palliative and end-of-life care	Comfort-focused care that continues after treatment is withdrawn	Treated in *Harish Rana* as inseparable from the right to die with dignity

The statutory background explains why the courts felt compelled to intervene. Under the Indian Penal Code, the victim's consent to death reduced murder to culpable homicide not amounting to murder (exception 5 to section 300) but did not excuse the killing, and abetment of suicide was an offence in its own right (section 306). The Bharatiya Nyaya Sanhita, 2023, which came into force on 1 July 2024, preserves the same architecture: culpable homicide is dealt with in sections 100 and 105, and abetment of suicide in section 108. The Sanhita also narrows the old offence of attempted suicide to the situation in which the attempt is made to compel or restrain a public servant (section 226). Legislative recognition of end-of-life choice is otherwise confined to the Mental Healthcare Act, 2017, which allows a person to make an advance directive about mental-health treatment; no comparable statute covers general medical treatment.

The constitutional footing is Article 21. Its reading has expanded from procedural fairness (*Maneka Gandhi v. Union of India*, 1978) to substantive dignity (*Francis Coralie Mullin v.*

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Administrator, Union Territory of Delhi, 1981), and, after *K.S. Puttaswamy v. Union of India* (2017) 10 SCC 1, to decisional autonomy and bodily integrity. It is this last strand, the individual's authority over what may be done to the body, that supports a right to refuse medical treatment. The conceptual challenge for the courts has been to keep that right distinct from any right to be killed.

3. Judicial Evolution: From Rathinam to Common Cause

The present law is best understood as the product of four decisions, each correcting or extending the last.

3.1 The right to life and the limits of a right to die

In *P. Rathinam v. Union of India* (1994) 3 SCC 394, a two-judge Bench struck down section 309 of the Penal Code, reasoning that the right to life must carry a corresponding freedom not to live a life one does not wish to live. That reasoning lasted barely two years. A Constitution Bench in *Gian Kaur v. State of Punjab* (1996) 2 SCC 648 overruled *Rathinam*, holding that Article 21 protects life and does not embrace its extinction, and upheld the penal provisions on attempted suicide and abetment of suicide.

The significance of *Gian Kaur* for present purposes lies in an observation that was not necessary to its decision. The Court distinguished an unnatural termination of life from the acceleration of an already-advancing natural death in a terminally ill or comatose patient, and suggested that the latter may fall within the right to live with dignity. Every later decision on passive euthanasia has been built on that passage.

3.2 Aruna Shanbaug: recognition without relief

Aruna Shanbaug v. Union of India (2011) 4 SCC 454 arose from the situation of a nurse who, after a brutal assault in 1973, spent decades in a persistent vegetative state at a Mumbai hospital. A petition filed on her behalf by a writer and activist, seeking to end her life support, was rejected: the Court held that the hospital staff who had cared for her throughout were her true next friends, and they wished her care to continue. Yet the judgment did more than dispose of the petition. It accepted that withdrawal of life support from a patient in her condition could be lawful, provided the High Court, acting under Article 226 on the report of a committee of doctors, gave prior approval, and it confirmed that active euthanasia could not be authorised without legislation.

The decision has been criticised on two counts. First, its reading of *Gian Kaur* stretched an

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observation into an authorisation. Second, the requirement of High Court approval in every case made the route practically unusable for families in a country with a heavy judicial backlog. Ms Shanbaug herself died in 2015 without the procedure ever being invoked.

3.3 Common Cause: a constitutional right and a working protocol

The doubts over how *Shanbaug* had read *Gian Kaur* led to a reference to a Constitution Bench in a writ petition brought by the non-governmental organisation Common Cause. On 9 March 2018, the five-judge Bench, through several concurring opinions, delivered the leading modern decision (*Common Cause v. Union of India*, (2018) 5 SCC 1). It held that the right to die with dignity is a facet of the right to life and personal liberty under Article 21. The State's interest in preserving life, it reasoned, cannot outweigh the patient's interest where treatment can no longer benefit the person and only prolongs the process of dying. The Court therefore validated passive euthanasia and gave legal force to advance medical directives, allowing a competent adult to state in advance the circumstances in which treatment should be refused or withdrawn. It also set out a step-by-step protocol, to operate until Parliament legislated, for cases both with and without a directive.

Two features of *Common Cause* deserve emphasis. It moved authority from the courtroom to a structured medical-review process, with judicial involvement kept for oversight. And it embedded the "best interest of the patient" principle as the guiding test whenever the patient cannot speak for himself. That second feature is the one the Court would later be asked to develop in *Harish Rana*.

4. The 2023 Modification of the Guidelines

The 2018 protocol proved difficult to operate. In July 2019 the Indian Society for Critical Care applied to the Supreme Court, arguing that the procedure was so laborious that it prolonged the suffering it was meant to end. In particular, it objected to the involvement of a Judicial Magistrate of the First Class, to the demanding experience thresholds for medical-board members, and to the need for two separate boards. On 24 January 2023 a Constitution Bench headed by Justice K.M. Joseph accepted a joint proposal put forward by the Society and the Union of India and modified the guidelines accordingly (Supreme Court Observer, 2023).

The changes are best read as a redistribution of authority from the judiciary to the medical profession, without removing external review altogether.

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Feature	2018 guidelines	2023 modification
Attestation of an advance directive	Signed before two witnesses and countersigned by a Judicial Magistrate of the First Class	Two witnesses, with attestation before a notary or gazetted officer
Primary medical board	Head of the treating department plus at least three experts with more than 20 years' experience	Minimum of three members, each with five years' experience
Secondary medical board	Constituted by the District Collector, including the district Chief Medical Officer and three experts of 20 years' standing	Chief Medical Officer nominates a member in his place; minimum of three members with five years' experience
Judicial Magistrate	Custody and onward transmission of the directive; oversight of the process	Informed of the boards' decision and of the consent of the relative or guardian named in the directive
Informing the family	Duty of the Magistrate	Duty of the person executing the directive

Both boards were also asked to decide, preferably within 48 hours. The Bench declined to abolish the second board despite the Society's request, and the modified procedure applies whether or not the patient left a directive. Two observations follow. First, the change was engineered through a negotiated proposal between clinicians and the executive, presented to the Court and adopted on the day of the final hearing. It therefore had many features of legislation without the deliberation that legislation would ordinarily involve. Second, the reform lowered procedural barriers but did nothing to solve the harder question of how to decide for a patient who never made a directive. That question came before the Court squarely in 2026.

5. Recent Developments (2024–2026)

Between 2024 and 2026 the framework moved from paper to practice. Executive draft guidance appeared, one State issued operating orders, and the Supreme Court decided the first case to run the full procedure.

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Date	Development	Significance
24 March 2026	Harish Rana dies at AIIMS Delhi after staged withdrawal of nutrition under a palliative plan (Gulf News)	First completed application of the framework
11 March 2026	*Harish Rana v. Union of India* (2026 INSC 222) (judgment)	CANH held to be medical treatment; best-interests standard elaborated
October 2025	Parents file an application; primary and secondary boards constituted (Supreme Court Observer)	Framework invoked before the Supreme Court
30 January to 14 February 2025	Karnataka issues three orders implementing the 2023 guidelines (Nivarana)	Most detailed State-level operating orders among those consulted
September 2024	Union Health Ministry releases draft guidelines on withdrawal of life support (ANI)	Executive attempt to operationalise the judicial framework
2024	Delhi High Court declines Rana's plea; Supreme Court issues notice to the Union in August (Supreme Court Observer)	Exposes uncertainty over whether nutrition is "treatment"

5.1 Executive guidance: the 2024 draft

In late September 2024 the Union Ministry of Health and Family Welfare released draft guidelines on withdrawal of life support in terminally ill patients and invited public comment until 20 October (ThePrint). The draft defines terminal illness as an irreversible or incurable condition in which death is inevitable in the foreseeable future, and it extends the category to severe traumatic brain injury with no recovery after 72 hours. It frames withholding or withdrawing life support as a considered decision in the patient's best interests. For a patient lacking capacity it envisages a primary board of at least three physicians, whose decision a secondary board of three, including a nominee of the district Chief Medical Officer, must validate, and it states that active euthanasia is not lawful (ANI). The president of the Indian Medical Association objected that the exercise added regulatory stress to decisions clinicians and families already take together (ANI). The draft signals that the Executive accepts the judicial framework as the basis for national guidance. Its limitation is that draft guidance cannot

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displace the Court's binding directions, and in the sources consulted for this article a final notified version was not located.

5.2 State implementation: the Karnataka circulars

Karnataka has acted in most detail among the States covered by the sources consulted. On 30 January 2025 its health department issued a circular conveying the Court's guidelines to the officers responsible for implementing them. A second order of the same date allowed hospitals to draw secondary-board members from specialists already approved to certify brainstem death under the transplantation law, and a third order, on 14 February 2025, designated the executive officer of the taluk panchayat as the officer to receive advance directives in rural areas (Nivarana). The orders create no new right; they discharge the State's duty to make the Court's guidelines workable. Their practical value is that hospitals with brainstem-death expertise can no longer plead the absence of a secondary board as a reason to discharge patients against medical advice, although settings without that expertise still need another route (Nivarana).

5.3 Harish Rana v. Union of India (2026)

Harish Rana sustained a diffuse axonal brain injury in a fall in 2013 and remained quadriplegic and dependent on nutrition delivered through a gastrostomy tube. His father's plea for withdrawal was declined by the Delhi High Court in 2024 on the reasoning that, since no ventilator was involved, stopping tube feeding would amount to starvation rather than passive euthanasia. The Supreme Court initially inclined the same way, but in 2025 constituted the two-tier boards, both of which found the damage irreversible (Supreme Court Observer). On 11 March 2026 Justices J.B. Pardiwala and K.V. Viswanathan permitted withdrawal. Four holdings stand out.

1. **Nutrition as treatment.** Clinically assisted nutrition and hydration is medical treatment, not basic care. It follows that its continuation or withdrawal is governed by the same clinical, ethical and legal principles as any other life-sustaining intervention, including when it is administered at home (Indian Association of Palliative Care).
2. **Best interests with substituted judgment.** The relevant question is not whether death is in the patient's interest, but whether prolonging life through the treatment is. The assessment weighs benefits against burdens and includes non-medical factors such as the patient's values, and the Court reasoned that Rana, previously an active and sporty young man, would not have chosen to continue (Supreme Court Observer).
3. **Palliative care as a component of the right.** Withdrawal must be gradual and humane

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under a written palliative plan, and the Court criticised the routine practice of discharge against medical advice as a substitute for such care (Indian Association of Palliative Care).

4. **Institutional directions.** District Chief Medical Officers must maintain panels from which a secondary-board member can be nominated, preferably within 48 hours; High Courts must instruct Magistrates to receive intimation where both boards are unanimous; and families may approach the High Court under Article 226 if a hospital fails to start the process (Indian Association of Palliative Care). Where both boards concur, the Court indicated that no further judicial intervention is required (Gulf News). Rana was moved to the palliative care unit at AIIMS Delhi on 14 March, his nutritional support was withdrawn over several days, and he died on 24 March 2026 (Gulf News). The Court closed by urging the Union to enact comprehensive end-of-life legislation.
5. **Comparative Perspective**

   Indian courts have borrowed heavily from foreign authority, and a short comparison shows both how closely the Indian position now tracks the common-law mainstream and where it remains thinner than its models.

Jurisdiction	Key authority	Approach	Lesson for India
United Kingdom	*Airedale NHS Trust v. Bland* [1993] AC 789; Mental Capacity Act 2005; *NHS Trust v. Y* [2018] UKSC 46	Artificial nutrition is medical treatment; decisions turn on best interests under a statutory checklist; court approval is needed only where there is disagreement	*Harish Rana* aligns with this line, but India lacks the statutory checklist and a defined class of cases that can proceed without a court
United States	*Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990); *Washington v. Glucksberg*, 521 U.S. 702 (1997)	A competent patient may refuse treatment, including nutrition; States may demand clear and convincing evidence of an incompetent patient's wishes; no constitutional right to assisted suicide	A defined evidentiary standard for inferring the patient's will, absent in India, protects against error in non-voluntary cases

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Netherlands	Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002	Euthanasia and assisted suicide lawful under statutory due-care criteria, reviewed after the event by regional committees	India has rightly kept the active/passive line, but the Dutch model shows the value of independent, documented review
Canada	*Carter v. Canada (Attorney General)* [2015] 1 SCR 331; medical assistance in dying legislation	Assisted dying lawful for eligible persons, with continuing debate over expansion	Illustrates the contested boundaries that follow once the passive/active line is crossed

Three points emerge. First, on the legal character of nutrition, India has now joined the English position after *Bland*, which had held withdrawal from a patient in a persistent vegetative state to be an omission of treatment rather than a positive act. The practical lesson of *NHS Trust v. Y* is that judicial approval can be reserved for contested cases when doctors and family agree, and *Harish Rana* points in the same direction by treating board unanimity as sufficient. Second, the American cases show how a legal system can protect vulnerable patients through an explicit evidentiary rule, whereas India's flexible best-interests inquiry leaves the weight of family testimony and inferred preferences to the discretion of decision-makers. Third, the Dutch and Canadian experience is not a model for India's present law, which rejects active euthanasia, but it demonstrates that any system dealing with end-of-life decisions needs a transparent record and an independent reviewer. The Court in *Harish Rana* itself drew on comparative material from several jurisdictions, as commentators have noted (Sengupta, 2026).

6. Critical Analysis

The Indian framework is humane and, after *Harish Rana*, workable. It is also fragile, for reasons that are legal, ethical and institutional.

6.1 Judicial legislation without a statute

The entire regime rests on guidelines framed by the Court "until Parliament legislates", a promise first made in *Aruna Shanbaug* and repeated in *Common Cause* and again in *Harish Rana*. The Law Commission of India has twice examined the subject, in its 196th Report (2006)

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and its 241st Report (2012), and a draft executive Bill was prepared in 2016, yet no statute exists. The consequence is that the Court's guidelines operate as de facto legislation, altered by consent orders and refined in individual cases, with no democratic deliberation over its trade-offs (Sengupta, 2026). For practitioners the result is uncertainty: no statutory safe harbour protects a doctor who complies in good faith, and criminal exposure under the Bharatiya Nyaya Sanhita depends on the courts' characterisation of the omission as lawful.

6.2 An under-specified best-interests test

The multi-factor test in *Harish Rana* is attractive because it avoids both paternalism and rigid deference to an unrecorded wish. But it fixes no evidentiary thresholds and no hierarchy among factors. Exhaustion, grief and financial strain may colour a family's perception of futility, particularly after years of home care, and the judgment does not ask whether independent psychological or social-work assessment should form part of the record. That omission matters less in a case with an evidently devoted family than it will in a case without one (Sengupta, 2026).

6.3 Dignity and disability

Dignity is a double-edged principle. India has ratified the UN Convention on the Rights of Persons with Disabilities and enacted the Rights of Persons with Disabilities Act, 2016, precisely because severe impairment has long been equated with a life not worth living. A capacious best-interests inquiry, if unbounded, risks importing that assumption into decisions about who may be allowed to die. The safer course, which this article supports, is to confine non-voluntary withdrawal to states of established permanent absence of awareness, verified by rigorous clinical criteria, and to distinguish them expressly from severe but conscious impairment.

6.4 Terminology and public understanding

The label "passive euthanasia" itself invites confusion. The Delhi High Court's 2024 reasoning shows the difficulty: it treated the absence of a ventilator as taking the case outside passive euthanasia altogether. Terms such as "limitation of life-sustaining treatment" describe more accurately what the law permits and separate it more cleanly from the killing that remains prohibited.

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6.5 Infrastructure and access

A right that depends on two medical boards, a district panel, a magistrate's intimation and a palliative plan is only as real as the institutions that deliver them. The Court itself observed that a right to die with dignity is inseparable from the right to good palliative care, yet one commentary, citing press reports, notes that fewer than four per cent of Indians who need palliative care receive it (Mehta, 2025), and the head of the petitioner organisation in *Common Cause* has observed that few States besides Kerala offer meaningful options (Supreme Court Observer, 2026). Even the Karnataka solution presupposes hospitals equipped to certify brainstem death, which excludes many smaller and rural facilities. Advance directives, moreover, presuppose awareness, literacy and access to a notary or gazetted officer. Without investment, the benefits of the framework will accrue mainly to urban, insured and well-advised families.

7. Recommendations: Towards an End-of-Life Care Statute

The analysis above points to a single institutional remedy: a comprehensive statute that converts the Court's guidelines into enacted law and fills the gaps the Court left open. Such a statute should contain at least the following elements.

1. **Right to refuse treatment and advance directives.** Recognise the right of every competent adult to refuse or discontinue treatment, and give statutory force to advance directives, supported by a portable, digitally accessible registry so that a directive is available when it is needed.
2. **A codified best-interests standard.** For patients without a directive, enact a checklist of medical and non-medical factors, a rebuttable presumption in favour of preserving life, an order of surrogate decision-makers, and a rule on the weight of family testimony. Require an independent psychosocial assessment where the decision rests on inferred wishes.
3. **Narrow eligibility for non-voluntary withdrawal.** Confine it to conditions of established permanent absence of awareness, defined by standard clinical criteria and a minimum observation period, and draw the line expressly against severe but conscious disability, consulting disability-rights bodies in framing the criteria.
4. **Settled definitions and terminology.** State that clinically assisted nutrition and hydration is medical treatment, and adopt the language of limitation or withdrawal of life-sustaining treatment in place of "passive euthanasia".
5. **Reliable machinery.** Fix time limits for board decisions, bar conflicts of interest,

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permit tele-consultation where specialists are scarce, keep the Magistrate's role as a recording authority, and provide a clear route to the High Court or a designated forum for contested cases.

6. **Protection for practitioners.** Provide immunity for good-faith compliance with the statutory procedure, and state plainly that active euthanasia remains an offence unless Parliament decides otherwise after a separate public debate.
7. **Palliative care as a duty.** Make palliative and end-of-life care a statutory obligation of institutions that withdraw treatment, fund its expansion in public hospitals and home care, and prohibit the use of discharge against medical advice as a substitute for a care plan.
8. **Transparency and review.** Require anonymised reporting of every decision to a national body, publish annual audits, and provide for parliamentary review of the statute after five years.
9. Until such legislation exists, State governments can follow the Karnataka model by issuing operational orders, and High Courts can complete the administrative directions given in *Harish Rana* so that Magistrates and district health officers are ready to act when a family invokes the process.

8. Conclusion

Three decades of case law have carried Indian law from a bare observation in *Gian Kaur* to a working, if judge-made, system for withdrawing life-sustaining treatment. *Common Cause* supplied the constitutional foundation and the first protocol; the 2023 modification made that protocol usable; and *Harish Rana* demonstrated, in a single case, that the whole machinery can run from medical board to palliative ward. In answer to the first research question, the governing principles are now these: passive euthanasia is lawful, active euthanasia is not, decisions for incapacitated patients turn on their best interests, and the decision must be carried out with palliative care rather than abandonment.

In answer to the second, *Harish Rana* added two things of lasting importance. It classified clinically assisted nutrition and hydration as medical treatment, closing a doctrinal gap that had left the most common form of life support outside the framework. And it developed the best-interests standard by blending it with substituted judgment, applying it for the first time to a patient who had left no directive.

In answer to the third, the framework's weaknesses lie where its strengths are most visible. A flexible best-interests test needs evidentiary discipline and disability-sensitive limits. Judicial

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guidelines need the stability that only legislation can give. And a right to a dignified death is hollow without palliative infrastructure. The Court has now asked Parliament to act three times over. A statute drawing on the elements proposed in Part 8 would answer that call while preserving what the Court has rightly insisted on: that the law should relieve prolonged dying without licensing the ending of life.

Note on currency: the article reflects sources available up to September 2026.

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