

INTERNATIONAL JOURNAL FOR LEGAL RESEARCH AND ANALYSIS



Open Access, Refereed Journal Multi Disciplinary
Peer Reviewed

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PASSIVE EUTHANASIA AND THE INSTITUTIONAL CHALLENGES OF END-OF-LIFE CARE IN INDIA

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ABSTRACT

“This article examines the implementation gap between the constitutional recognition of the right to die with dignity and its practical accessibility in India through an analysis of the Supreme Court’s February 2026 order in order in Harish Rana v. Union of India. This order operationalised passive euthanasia for an individual under the Common Cause framework. The bureaucratic provisions embedded in the Common Cause guidelines are animated by concerns of misuse and assumptions of uniform institutional capacity across India. Even after the 2023 modifications simplified certain procedural requirements, the petitioner’s family’s demonstrates that it that procedural simplification without institutional infrastructure achieves little. This article traces the evolution of euthanasia jurisprudence from P Rathinam to Common Cause, identifies unresolved issues concerning patient autonomy and advance directives, examines structural barriers like bureaucratic procedures, rural access problems and the deficit in end-of-life care infrastructure. A comparative analysis of the United Kingdom, Canada and the Netherlands also offers alternative models that privilege clinical judgment and decentralised oversight. The article concludes that India requires comprehensive legislation, accessible medical decision-making mechanisms such as district-level review committees and telemedicine-based boards and stronger end-of-life care policies to transform a constitutionally recognised right into a practically realisable one.”

INTRODUCTION

The discourse on euthanasia sits at the intersection of medicine, ethics and constitutional law. It also brings into discussion key questions on the nature of life, meaning of dignity and the limits of state power over autonomy. It is, in equal measure, a healthcare question: end-of-life decisions are actually taken by treating physicians, hospitals and medical boards, and turn on consent, clinical judgment and the availability of palliative care, not on constitutional doctrine alone. At its core, lies the question of whether a person suffering from an incurable condition

with no chance of recovery, has a right to choose a dignified death over an artificially sustained existence. In India, the legal framework that recognises the right to die with dignity has evolved over judicial pronouncements by the Supreme Court (“SC”) over the last three decades. Courts have interpreted it as an intrinsic facet of Article 21¹.

By its recent judgement in *Harish Rana v. Union of India*², the SC permitted passive euthanasia for an individual under the *Common Cause* guidelines³. The petitioner had languished in a persistent vegetative state for thirteen years following a traumatic head injury leading to a condition of 100% disability with quadriplegia⁴. He became subject to an order directing the constitution of a Secondary Medical Board (“SMB”) to evaluate whether life sustaining treatment could be withdrawn. A team of four specialists determined that his chances of recovery were negligible.

This case becomes important, not merely because of its outcome, but for what it reveals about end of life care in India. The Rana family’s struggle in activating the procedural machinery established in the *Common Cause* guidelines and obtaining the present order highlights the persistent judicial intervention required at every step of the procedure.

This article argues that India's right to die with dignity remains inaccessible to most citizens despite being constitutionally acknowledged. The bureaucratic procedures embedded in the *Common Cause*⁵ guidelines assume institutional capacity that does not exist uniformly across India while lack of for rural populations renders the framework merely theoretical for vast populations. Further, the lack of end-of-life care infrastructure leaves families with no practical mechanism to invoke the law. The *Common Cause* judgment missed the opportunity to acknowledge that a large number of people in India are forced to embrace an undignified death due to lack of resources, roots traceable to a poorly funded public healthcare system and an unaffordable private healthcare system⁶. The Harish Rana case serves as a lens through which to examine this implementation gap, revealing that even with proximity to the SC, the framework could not function without judicial oversight.

¹ The Constitution of India, art 21.

² *Harish Rana v Union of India* Miscellaneous Application No 2238/2025 in SLP (C) No 18225/2024 (SC, order dated 11 December 2025).

³ *Common Cause (A Regd Society) v Union of India* AIR 2018 SC 1665.

⁴ LiveLaw, ‘Supreme Court Allows First Passive Euthanasia, Permits Withdrawal Of Life Support For Man In Vegetative State’ (11 March 2026) <<https://www.livelaw.in/amp/top-stories/supreme-court-allows-first-passive-euthanasia-permits-withdrawal-of-life-support-for-man-in-vegetative-state-525943>> accessed 23 March 2026.

⁵ *ibid*.

⁶ Sunita VS Bandewar, Leni Chaudhuri, Lubna Duggal and Sanjay Nagral, ‘The SC of India on Euthanasia: Too Little, Too Late’ (2018) 3(2) Indian Journal of Medical Ethics.

EVOLUTION OF EUTHANASIA JURISPRUDENCE IN INDIA

In order to understand the present case, it is necessary to trace the judicial evolution that made it possible.

India's earliest judicial engagement with the right to die came in *P. Rathinam v. Union of India*⁷ where a division bench sought to consider the constitutionality of Section 309⁸ of the IPC. The SC held that Article 21⁹ included the right not to live a forced life, reasoning that the right to live included the right to die. However, this expansive interpretation was short lived.

In *Gian Kaur v. State of Punjab*¹⁰, a Constitution Bench overruled Rathinam, holding that Article 21 did not include a general right to die. However, the court observed that the right to live with dignity could extend to permitting a dying man to die with dignity when life was ebbing out¹¹. Therefore, this interpretation opened the possibility of the withdrawal of life sustaining treatment in terminal situations being constitutionally permissible.

The Law Commission of India also examined this issue around the same time in its 196th Report on the Medical Treatment to Terminally Ill Patients (Protection of Patients and Medical Practitioners). It recommended that euthanasia and physician assisted suicide should remain illegal while withdrawing life-sustaining treatment from terminally ill patients could be legally permissible¹².

*Aruna Shanbaug v. Union of India*¹³ ("**Aruna Shanbaug**") brought the next major development, which arose from the tragic circumstances of a nurse who had been sexually assaulted in 1973, which resulted in neurological damage that left her in persistent vegetative state for the next 38 years. The Court permitted a journalist to file a petition as Aruna's next friend, seeking permission to withdraw artificial feeding. Further, while interpreting *Gian Kaur* and its implicit approval of the House of Lords' decision in *Airedale NHS Trust v. Bland*¹⁴, the SC held that passive euthanasia could be legally permissible in India in exceptional circumstances. However, the court expressed caution over its potential misuse by doctors, family members and unscrupulous persons, thereby mandating approval by the jurisdictional

⁷ *P Rathinam v Union of India* 1994 SCC (3) 394.

⁸ The Indian Penal Code, 1860 (45 of 1860) s 309.

⁹ The Constitution of India, art 21.

¹⁰ *Gian Kaur v State of Punjab* 1996 SCC (2) 648.

¹¹ Akshat Agarwal, 'Towards A "Good Death": Uncovering the Confusion In End-Of-Life-Care Law in India' (2023) 16(1) NUJS Law Review.

¹² Law Commission of India, *Medical Treatment of Terminally Ill Patients (Protection of Patients and Medical Practitioners)*, Report No 196 (March 2006)

¹³ *Aruna Ramchandra Shanbaug v Union of India* AIR 2011 SC 1290.

¹⁴ *Airedale NHS Trust v Bland* [1993] 1 All ER 821.

High Court (“HC”) after consultation with a panel of medical experts¹⁵. This effectively judicialised end-of-life decisions and made the process dependent on the intervention of constitutional courts. Soon, the Law Commission of India in its 241st Report revisited the issue and largely endorsed the framework suggested in *Aruna Shanbaug*.

However, the limitations of *Aruna Shanbaug* led to the guidelines established by a 5 Judge bench of the SC in *Common Cause v. Union of India*¹⁶ (“**Common Cause**”). Emphasizing on autonomy in medical decision making, it drew heavily from jurisprudence in *KS Puttuswamy v. Union of India*¹⁷ to recognize the Right to Die with Dignity and the legality of advance directives. Further, reference was made to Justice K. Ramaswamy's observation in *CESE Ltd. v. Subhash Chandra Bose*¹⁸ about health enabling exercise of civil and political rights¹⁹. While active euthanasia remained illegal, the Court reaffirmed that withdrawal of life support through passive euthanasia would not have the effect of homicide as it led to death in the natural course²⁰.

To operationalise this right, the Court laid down the following procedural safeguards for end-of-life decision-making:

- i. Recognition of advance directives allowing competent individuals to refuse future life-sustaining treatment.
- ii. Execution requirements for advance directives, including signature by the patient and attestation by witnesses with authentication by a Judicial Magistrate.
- iii. Primary Medical Board (“**PMB**”) review, where the treating hospital constitutes a board of physicians to assess whether continued life-sustaining treatment is medically futile.
- iv. SMB confirmation, providing an independent medical opinion before withdrawal of treatment.
- v. Judicial oversight through intimation to the jurisdictional Magistrate, ensuring procedural transparency and safeguarding against misuse.

These guidelines were further simplified in 2023 with magistrate attestation of advance directives being replaced with attestation by a notary or gazetted officer and the role of judicial

¹⁵ Akshat Agarwal, ‘Towards A “Good Death”: Uncovering the Confusion In End-Of-Life-Care Law in India’ (2023) 16(1) NUJS Law Review.

¹⁶ *Common Cause (A Regd Society) v Union of India* AIR 2018 SC 1665.

¹⁷ *KS Puttuswamy v Union of India* AIR 2017 SC 4161.

¹⁸ *CESE Ltd v Subhash Chandra Bose* AIR 1992 SC 573.

¹⁹ Sunita VS Bandewar, Leni Chaudhuri, Lubna Duggal and Sanjay Nagral, ‘The SC of India on Euthanasia: Too Little, Too Late’ (2018) 3(2) Indian Journal of Medical Ethics.

²⁰ *Common Cause (A Regd Society) v Union of India* AIR 2018 SC 1665.

authorities clarified as entities receiving intimation rather than granting permission²¹. Further, SMB were allowed to be constituted at district hospitals where government medical colleges were unavailable. Even though these modifications reduced certain procedural hurdles, concerns over accessibility and institutional capacity continued to remain.

Three conceptual tensions emerging from this jurisprudence would later shape the debate: the balance between patient autonomy and state imposed safeguards; and the distinction between passive euthanasia and withdrawal of treatment²².

This was the legal landscape that confronted the SC when Harish Rana's father approached it in 2025. The Court did not create new law. Instead, it applied the framework developed in *Common Cause* by directing the constitution of a PMB, considering its medical assessment, and subsequently ordering the constitution of a SMB in accordance with the existing guidelines.

THE HARISH RANA ORDER

The case came before the SC through a Special Leave Petition in 2024, after proceedings were initiated before the Delhi HC seeking constitution of a medical board. In an order dated 8 November 2024, the SC disposed of the petition after the Union of India proposed alternatives such as home-based medical care with state support or shifting him to a district hospital²³. The parents agreed to this arrangement, and liberty was granted to approach the Court again if necessary.

The family, however again returned to the Court by way of a Miscellaneous Application alleging that the above arrangements had not addressed the core issue. The family sought primary relief in the form of declaration that clinically assisted nutrition and hydration constitutes life sustaining treatment to enable its withdrawal²⁴. Further, they wished to activate the Common Cause framework and directions for the constitution of Primary and Secondary Medical Boards.

The PMB, constituted pursuant to the Court's directions on November 26, 2025 conducted a detailed evaluation at the petitioner's residence. The Board noted that he was bedridden, emaciated and had severe contractures in all limbs. He required a Tracheostomy Tube for

²¹ Akshat Agarwal, 'Towards A "Good Death": Uncovering the Confusion In End-Of-Life-Care Law in India' (2023) 16(1) NUJS Law Review.

²² *Common Cause (A Regd Society) v Union of India* AIR 2018 SC 1665.

²³ BarandBench, 'In a first, Supreme Court allows passive euthanasia of man in vegetative state since 2013' (11 March 2026) <<https://www.barandbench.com/news/supreme-court-allows-passive-euthanasia-of-man-in-vegetative-state-since-2013>> accessed 23 March 2026.

²⁴ Abhijit Chakravarty and Pawan Kapoor, 'Concepts and Debates in End-of-Life Care' (2012) 9(3) Indian Journal of Medical Ethics.

Breathing and a Gastronomy tube for feeding. Even though brainstem reflexes were present, he remained entirely dependent on external support for basic bodily functions. The report also recorded extensive bed sores and concluded that the chances of recovery were negligible. On 11 December 2025, the Court proceeded to the next stage and directed the constitution of a SMB, requesting the Director of AIIMS Delhi to constitute the Board and submit its report within a fixed timeline.

The activation of the Common Cause framework becomes evident in this process. The Rana family's experience illustrates how the PMB provides a preliminary opinion on whether continued life-sustaining treatment is medically futile, while the SMB offers an independent confirmation before any decision to withdraw treatment can be taken. Read this way, the case is not only about what the Court permitted, but about how a medical board actually assesses futility once a hospital is directed to convene one: the clinical findings of bedsores, contractures and negligible prospects of recovery, not legal doctrine, are what carried the decision.

The 2023 modifications had simplified the procedure on paper, replacing magistrate attestation with notary approval, clarifying judicial oversight as intimation rather than permission and permitting SMB at district hospitals²⁵. Yet for the Rana family, these simplifications proved meaningless. No notary had been approached and no district hospital had constituted a board. The family still required the SC to direct each step, revealing that procedural simplification without institutional infrastructure achieves little.

CONCEPTUAL ISSUES IN END-OF-LIFE LAW

Before examining structural barriers, it is necessary to address certain conceptual distinctions that the Harish Rana order implicitly engages with. These distinctions carry significant implications for how end-of-life decisions are understood. Four conceptual tensions underlie the end of life discourse: first, the tension between sanctity of life and dignity in death; second, the balance between patient autonomy and state imposed safeguards; third, the distinction between passive euthanasia and withdrawal of treatment; fourth, relates to advance directives. Each carries significant implications for how decisions like Harish Rana's are understood.

The first distinction, between passive euthanasia and withdrawal of treatment, is frequently obscured. Passive euthanasia refers to the intentional withholding or withdrawing of life-sustaining treatment with knowledge that this will result in death. Withdrawal of treatment, as medical literature notes, is defined as the removal of a therapy started to sustain life but which

²⁵ Akshat Agarwal, 'Towards A "Good Death": Uncovering the Confusion In End-Of-Life-Care Law in India' (2023) 16(1) NUJS Law Review.

has become futile and is merely prolonging the dying process²⁶. Withholding, strictly, refers to a decision never to commence a given intervention, while withdrawal refers to discontinuing one already in progress; the Common Cause framework, like most clinical ethics literature, treats the two as morally equivalent, though families and treating doctors often experience them very differently in practice. Clinical paradigms of futile care involve life-sustaining interventions where a physician determines that a therapy will be of no benefit²⁷. The ethical justification rests on a judgment that continued intervention serves no meaningful purpose. The *Common Cause*²⁸ court adopted this reasoning, observing that passive euthanasia leads to death in the natural course. The *Aruna Shanbaug*²⁹ judgement for its part used these terms interchangeably, a conflation that contributed to conceptual confusion in public discourse.

The determination of medical futility follows a structured process: deliberation with the medical team and family, exploration of alternatives in case of disagreement and closure once all options are exhausted³⁰. The judgement in *Common Cause* implicitly relied on this logic when it observed that passive euthanasia leads to death in the natural course, the treatment being withdrawn is not life sustaining in any meaningful sense, but merely medically useless³¹. The second distinction concerns physician-assisted suicide versus euthanasia. In physician-assisted suicide, the doctor provides the means but the patient performs the act. In euthanasia, the doctor directly causes death³². The key difference lies in the role of the patient in exercising autonomy and self-direction. In euthanasia, the patient is a passive recipient; in PAS, the patient actively participates in a conscious decision-making process. Indian law permits neither, confining itself to passive euthanasia.

The third issue concerns patient autonomy as the philosophical bedrock of *Common Cause*³³, which brought self determination on a higher footing while drawing from *Puttaswamy*³⁴. The right to refuse medical treatment flows from autonomy over one's body. A competent patient's decision must be respected even if it leads to death. This mirrors the ordinary law of informed consent, under which the Supreme Court in *Samira Kohli v Dr Prabha Manchanda* held that a

²⁶ Abhijit Chakravarty and Pawan Kapoor, 'Concepts and Debates in End-of-Life Care' (2012) 9(3) Indian Journal of Medical Ethics.

²⁷ *ibid.*

²⁸ *Common Cause (A Regd Society) v Union of India* AIR 2018 SC 1665.

²⁹ *Aruna Ramchandra Shanbaug v Union of India* AIR 2011 SC 1290.

³⁰ Abhijit Chakravarty and Pawan Kapoor, 'Concepts and Debates in End-of-Life Care' (2012) 9(3) Indian Journal of Medical Ethics.

³¹ *Common Cause (A Regd Society) v Union of India* AIR 2018 SC 1665.

³² Abhijit Chakravarty and Pawan Kapoor, 'Concepts and Debates in End-of-Life Care' (2012) 9(3) Indian Journal of Medical Ethics.

³³ *Common Cause (A Regd Society) v Union of India* AIR 2018 SC 1665.

³⁴ *KS Puttuswamy v Union of India* AIR 2017 SC 4161.

doctor must obtain a patient's real and informed consent before any procedure, and cannot treat consent to one intervention as consent to another merely because a physician judges it to be in the patient's interest.³⁵ Both lines of authority rest on the same premise, that the decision to accept or decline a medical intervention belongs to the patient and not to the treating doctor, though as the discussion below shows, *Common Cause* departs from this premise more readily than ordinary consent law does. However, as critics have noted, the *Common Cause*³⁶ framework compromised this autonomy by involving multiple players, effectively allowing medical boards to override patient wishes³⁷. The guidelines disregarded patient autonomy and failed to account for surrogate decision-making³⁸.

The fourth issue relates to advance directives. Three types are practised globally: a living will expressing desires regarding future treatment when death is imminent; durable power of attorney naming a surrogate decision-maker; and a terminal care document expressing choices about specific treatments including mechanical ventilation, nutrition, and hydration. The *Common Cause* framework adopted the written directive model, requiring attestation by two witnesses and a notary or gazetted officer³⁹.

The judgment also has implications for the draft Medical Treatment of Terminally Ill Patients Bill, 2016, still pending before Parliament. Clause 11 of this Bill considers advance directives void and not binding on any medical practitioner⁴⁰. *Common Cause*, by upholding advance directives, implicitly rejects this blanket ban. This is not a merely academic disagreement between a pending Bill and a decided case: the National Medical Commission Act, 2019, which now governs the registration and professional conduct of doctors, says nothing about the weight a treating physician must give to a patient's documented wishes, leaving *Common Cause* as the only real guidance a doctor has when an advance directive and a family's contrary instructions come into conflict at the bedside.⁴¹

Despite constitutional recognition, advance directives remain unused. The procedure is unfamiliar. Public awareness is minimal. Cultural discomfort with planning for death limits uptake. Studies on surrogate decision-making find proxy decisions often inaccurate regarding

³⁵ *Samira Kohli v Dr Prabha Manchanda* (2008) 2 SCC 1.

³⁶ *Common Cause (A Regd Society) v Union of India* AIR 2018 SC 1665.

³⁷ Sunita VS Bandewar, Leni Chaudhuri, Lubna Duggal and Sanjay Nagral, 'The SC of India on Euthanasia: Too Little, Too Late' (2018) 3(2) Indian Journal of Medical Ethics.

³⁸ Akshat Agarwal, 'Towards A "Good Death": Uncovering the Confusion In End-Of-Life-Care Law in India' (2023) 16(1) NUJS Law Review.

³⁹ *Common Cause (A Regd Society) v Union of India* AIR 2018 SC 1665.

⁴⁰ Sunita VS Bandewar, Leni Chaudhuri, Lubna Duggal and Sanjay Nagral, 'The SC of India on Euthanasia: Too Little, Too Late' (2018) 3(2) Indian Journal of Medical Ethics.

⁴¹ The National Medical Commission Act, 2019 (30 of 2019).

patients' previously expressed wishes.

The Harish Rana case illustrates the gap between constitutional recognition and practical reality. Harish had no advance directive. His parents decided, but the framework that should have facilitated their decision required SC intervention at every turn demonstrating that even the simplified 2023 guidelines remain inaccessible without judicial oversight.

STRUCTURAL CHALLENGES IN INDIA

Despite the Constitutional recognition of the right to die with dignity, the infrastructure to access this remains largely inaccessible to the masses. This is due to bureaucratic procedures, uneven infrastructure and the presumption of a coherent end of life framework.

Bureaucratic Procedures and the Limits of the 2023 Modification

India's present procedural architecture, as embodied in the *Common Cause* guidelines, reflects persistent judicial anxiety about misuse. This was evident in the judgement's sustained emphasis on concerns about 'unscrupulous persons' colluding with medical professionals, a suspicion that continued to shape the framework even after the 2023 modifications. This resulted in a restrictive framework requiring multiple layers of authorization before medical treatment could be withdrawn, as evidenced by the formation of a Primary and Secondary Medical Boards, coupled with intimation to a Judicial Magistrate. This creates a system of layered verification that prioritises institutional control over patient autonomy⁴².

The experience of the Rana family illustrates this limitation, as they were compelled to approach the Apex Court to activate this simplified framework, as the constitution of the PMB, submission of its report and the formation of the SMB occurred only pursuant to judicial direction. A constitutionally recognised right that depends on a Primary Medical Board, a Secondary Medical Board and a notary being reachable from the patient's home is, in the districts where none of these exist, a right that cannot in practice be exercised at all.

Rural Access and the Problem of Institutional Absence

Access to healthcare in India remains unevenly distributed, with district hospitals often lacking specialist depth in neurology, critical care and end of life management. As per the Rural Health Statistics 2021-22, there is a shortfall of 83.2% of surgeons, 74.2% of obstetricians & gynaecologists, 79.1% of physicians and 81.6% of paediatricians at Community Health Centres

⁴² *Common Cause (A Regd Society) v Union of India* AIR 2018 SC 1665.

across India⁴³. The Common Cause framework erred by assuming the availability of such expertise for constituting medical boards, despite such infrastructure being majorly concentrated in Urban India⁴⁴. This persists despite the 2023 modifications.

The Rana family's experience in navigating this framework from Ghaziabad, a city adjacent to Delhi with access to advanced medical institutions demonstrates that the barriers are not merely geographical. Rather, they reflect a broader institutional gap in translating legal rights into accessible procedures.

One potential solution to the specialist gap lies in integrating telemedicine into the medical board framework. The Telemedicine Practice Guidelines issued by the National Medical Commission provide a regulatory foundation for remote consultations.⁴⁵ Under such a model, district hospitals could constitute virtual SMB with specialists from tertiary institutions participating via video conference to review medical records and interact with the treating team. This would allow families in remote areas to access requisite expertise without requiring physical travel. Such a model, however, raises questions the Telemedicine Practice Guidelines were never drafted to answer: whether a specialist who has examined a patient only over video, without bedside access or physical imaging, can be said to have formed the independent clinical opinion that Common Cause requires of an SMB; who bears responsibility for that opinion if it later proves wrong; and whether such a specialist would even have secure access to records held at a hospital in another state. The Common Cause framework, however, has not incorporated this possibility, nor addressed remote participation at all.

A further reform would be the establishment of district level review committees, modelled on the Dutch approach. Composed of a physician, a legal officer and an ethicist or social worker, could be constituted by the District Magistrate in consultation with the Chief Medical Officer. Their function would be to receive PMB reports, facilitate the constitution of Secondary Boards from available specialists (including through telemedicine) and provide final administrative clearance withdrawal of life support. This would replace the need for families to approach HCs or the SC.

End-of-Life Care Deficit and the Limits of the Legal Framework

The Indian Council of Medical Research defines end of life care as the approach that prioritises

⁴³ Ministry of Health and Family Welfare, Rural Health Statistics 2021–22 (Government of India 2023) 45

⁴⁴ Sunita VS Bandewar, Leni Chaudhuri, Lubna Duggal and Sanjay Nagral, 'The SC of India on Euthanasia: Too Little, Too Late' (2018) 3(2) Indian Journal of Medical Ethics.

⁴⁵ Board of Governors in supersession of the Medical Council of India, Telemedicine Practice Guidelines (25 March 2020), issued under the Indian Medical Council Act, 1956.

comfort, dignity and quality of dying over curative treatment. It also emphasises the importance of palliative care as an approach that improves the quality of life of patients and their families battling with life threatening illness by prevention and relief of suffering.⁴⁶ The two are connected in a way the Common Cause framework does not fully acknowledge: the quality of palliative care available to a patient shapes what remains of their life, and that, in turn, is what a medical board is actually assessing when it decides whether continued treatment serves any purpose beyond prolonging dying. A patient with access to pain relief, psychological support and family presence experiences a very different remaining life than one without, even where the underlying prognosis is identical, and a decision to withdraw treatment taken without that support is a decision taken without the information a medical board needs. India also performs very poorly in this regard, as noted in a 2021 study which ranked it as 59th out of 81 countries examined in the quality of life and dying⁴⁷.

The present framework only operates meaningfully for a limited class of patients who can access advanced medical institutions and have the financial capability to navigate procedural requirements. This gap in access to the Common Cause framework has two consequences:-

- i. Patients who might benefit from Palliative Care are instead subjected to life sustaining treatment without adequate support.
- ii. Absence of institutional access means families remain unaware of their legal options or are unable to exercise them without judicial assistance.

A further concern arises from Justice Sikri's opinion in Common Cause, which raised the question of whether scarce medical resources should be spent on patients with no prospects of recovery⁴⁸. This shifts the discourse from dignity to cost. As India grapples with an underfunded public healthcare system and expensive private care, this approach becomes problematic as it does not adequately engage with the state's obligation to provide affordable healthcare. Thereby, it undermines Article 21 and normalises a framework where the inability to afford treatment becomes relevant to decisions on death.

⁴⁶ Indian Council of Medical Research, 'Definition of Terms Used in Limitation of Treatment and Providing Palliative Care at End of Life' (12 March 2018) <https://main.icmr.nic.in/sites/default/files/Books/Definition_of_terms_used_in_limitation_of_treatment_and_providing_palliative_care_at_end_of_life.pdf> accessed 23 March 2026.

⁴⁷ Eric A. Finkelstein, 'Cross Country Comparison of Expert Assessments of the Quality of Death and Dying 2021' (2022) 63(4) Journal of Pain and Symptom Management.

⁴⁸ Sunita VS Bandewar, Leni Chaudhuri, Lubna Duggal and Sanjay Nagral, 'The SC of India on Euthanasia: Too Little, Too Late' (2018) 3(2) Indian Journal of Medical Ethics.

COMPARATIVE PERSPECTIVE

The structural challenges facing India's framework becomes clearer when viewed against approaches adopted elsewhere.

In the UK, the House of Lords decision in *Airedale NHS Trust v Bland*⁴⁹ is the principal authority on Euthanasia. It established that withdrawal of Artificial nutrition and hydration from Permanent Vegetative State patients may be lawful if continues treatment is not in the patient's best interests, after taking due approval from court. This provision is criticized for causing delay and procedural complexity and has led to debates in British society on withdrawing treatment when families and clinicians agree. This shift away from routine litigation was confirmed by the Supreme Court itself in *An NHS Trust and others v Y*, which held that court approval is not mandatory before withdrawing clinically assisted nutrition and hydration from a patient with a prolonged disorder of consciousness where the Mental Capacity Act 2005 and relevant professional guidance, principally the BMA and Royal College of Physicians' joint guidance on CANH endorsed by the GMC, have been followed and the treating team and family agree, with an application to court remaining necessary only where the decision is finely balanced or there is disagreement⁵⁰ — a division of labour between clinical judgment and litigation, confined to this category of case, that Common Cause does not attempt. In addition to this, empirical research shows the court process is slow and emotionally burdensome.

By contrasts, Canada permits physician assisted death under the Medical Assistance in Dying (MAiD) legislation introduced after the SC decision in *Carter v. Canada*⁵¹. Through Federal Criminal, physicians to administer or prescribe lethal medication to competent adults suffering from grievous or irremediable medical conditions. It includes safeguards through independent medical assessments and written consent, which is enforced through provincial medical regulatory bodies.

Taking a different approach, the Netherlands however permits active euthanasia and assisted suicide through its Termination of Life on Request and Assisted Suicide Act. The Dutch model also decentralises decision making to physicians with oversight through regional review committees comprising of lawyers, physicians and ethicists⁵². In the Netherlands, studies

⁴⁹ *Airedale NHS Trust v Bland* [1993] 1 All ER 821.

⁵⁰ *An NHS Trust and others v Y* [2018] UKSC 46; British Medical Association and Royal College of Physicians, *Clinically-Assisted Nutrition and Hydration (CANH) and Adults Who Lack the Capacity to Consent: Guidance for Decision-Making in England and Wales* (2018), endorsed by the General Medical Council.

⁵¹ *Carter v Canada (Attorney General)* [2015] 1 SCR 331.

⁵² Abhijit Chakravarty and Pawan Kapoor, 'Concepts and Debates in End-of-Life Care' (2012) 9(3) Indian Journal of Medical Ethics 202.

revealed that loss of control and tiredness of life were most frequently reported than pain as reasons for requesting euthanasia.

India's position stands in contrasts to each of these models. Unlike the UK, which has moved toward reducing court involvement in uncontested cases, India's framework retains judicial oversight at every stage. Unlike Canada, which has enacted comprehensive legislation providing clear eligibility criteria and standardised procedures, India relies on judicial guidelines that vary in implementation. Unlike the Netherlands, which decentralises decision making through regional review committees, India centralises oversight in the higher judiciary. These experiences offer lessons. Clinical primacy with courts reserved for disputes is common to all three. Legislative clarity provides predictability. Decentralised oversight through district-level committees could provide accountability without requiring families to approach HC. Mandating clinical ethics committees would create local capacity.

CONCLUSION

The Harish Rana case has offered a moment of clarity as this was the first time a family successfully navigated the *Common Cause* framework to obtain withdrawal of life sustaining treatment. However, the manner in which that success was obtained exposes the framework's fault lines as petitioner's family, with access to the country's best medical institutions could not move the process forward without the SC intervening at every stage, notwithstanding a functioning treating hospital and specialists within reach. What the case ultimately shows is that a right of this kind cannot be secured by constitutional recognition alone; it has to be built into the ordinary functioning of hospitals, medical boards and palliative care services, so that families are not driven to the Supreme Court merely to have a treating doctor's clinical opinion acted upon.

This was not failure of the Judiciary, which laid down the framework, but a failure of the framework's assumptions. The *Common Cause* guidelines assumed that every district would have specialists available for medical boards, notaries and magistrates would be within reach and that families would know the procedures and have the resources to follow it. Despite the 2023 modifications simplifying this framework, the Rana family's experience shows that procedural simplification without institutional infrastructure achieves little.

In addition to this, the order in February did not resolve issues like distinction between passive euthanasia and withdrawal of treatment and the question of who decides when the patient has left no advance directive, a question that *Aruna Shanbaug* framed but *Common Cause* did not answer returned in Harish Rana's case, where his parents decided because he could not. Further,

the balance between patient autonomy and state safeguards remains tilted toward the latter.

Comparative experience with foreign jurisdictions offers a way forward in this regard. The United Kingdom, Canada and the Netherlands have developed models that privilege clinical judgment, decentralise oversight and reserve courts for disputes rather than routine decisions. However, India's framework goes in the opposite directions as it centralises oversight in the higher judiciary and leaves no room for local decision-making.

Therefore, a complete legislative and institutional reset through an End of Life Care Act is the solution to this, as it would provide statutory recognition and standardised procedures that do not depend on judicial availability. Further, District level review could provide oversight without requiring families to approach HCs. Also, Telemedicine-based medical boards could bridge the specialist gap. Hospital ethics committees would create local capacity for end-of-life decisions.

Further, economic considerations raised by Justice Sikri in Common Cause must be approached with care as India is a country where healthcare is unevenly distributed and private care often unaffordable. Thus, such reasoning risks becoming a justification for state abandonment rather than a legitimate consideration in end-of-life decisions.

In conclusion, the Harish Rana case shows how far India's jurisprudence on right to die with dignity has evolved. However, it also reveals that it still has very far to go, as the promise of Article 21 must extend to all citizen, regardless of geography and not be limited by proximity to the SC and resources to navigate procedural requirements.

IJLRA