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ARTICLE 21 · LIVING WILL

The Right to Die with Dignity

From criminalisation to constitutional recognition



India's Journey toward End-of-Life Autonomy and Permissive Treatment Withdrawal post *Harish Rana* Judgment by the Supreme Court.

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This article critically examines India’s constitutional and jurisprudential journey on end-of-life autonomy, Advance Medical Directives (“Living Wills”), and the withdrawal of life-sustaining medical treatments.

While an ordinary testamentary Will governs the posthumous distribution of property, a Living Will operates during an individual’s lifetime, recording medical preferences for a future point at which decision-making capacity is lost.

India’s legal position on dying with dignity has as yet moved through five distinct phases:

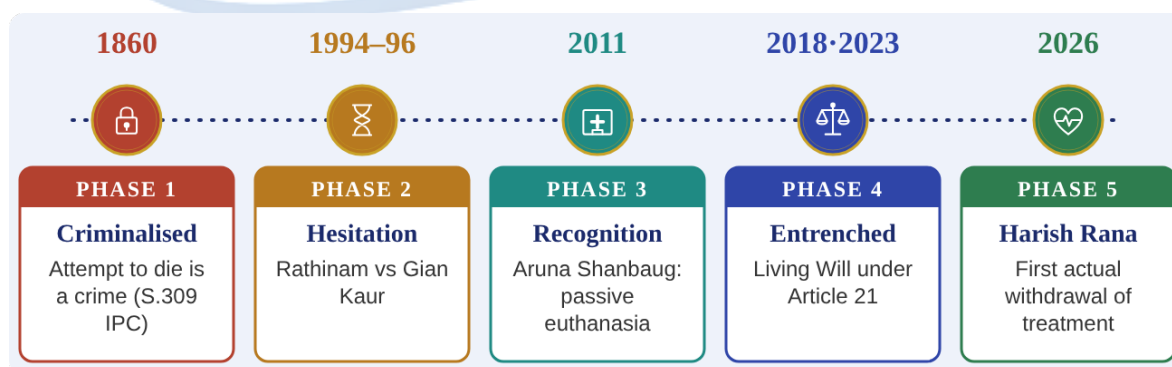
Phase 1: The absolute criminalisation of self-inflicted death under Section 309 of the Indian Penal Code, 1860;

Phase 2: The judicial hesitation between P. Rathinam judgment (1994) and Gian Kaur judgment (1996);

Phase 3: The first judicial recognition of passive euthanasia by the Apex Court in Aruna Shanbaug case (2011);

Phase 4: The constitutional entrenchment of the right to die with dignity under Article 21 in Common Cause (2018) judgment and its procedural simplification in 2023; and

Phase 5: The milestone ruling in *Harish Rana v. Union of India* (2026 INSC 222) judgment, the first case in which the simplified Common Cause framework was applied end-to-end to authorise an actual withdrawal of life-sustaining medical treatments.



This article critically evaluates the unresolved gaps in the Harish Rana framework and maps the institutional bottlenecks that continue to separate the law on paper from the law in



practice. The Article concludes with specific legislative and administrative recommendations aimed at closing that gap.



CULTURAL AND HISTORICAL ANTECEDENTS

Long before medical science created the possibility of prolonged artificial survival, Indian cultural and philosophical traditions had already engaged with the idea of a voluntary, chosen death, not as an act of despair, but as an act of spiritual completion through the following practices:

- **Iccha Mrityu** — revered in Indian history and ancient literature as a rare spiritual power, granting the holder of the capacity to choose the precise moment of departure from mortal existence. Well-known examples include Bhishma Pitamaha (of the Mahabharata Era) and Adi Shankaracharya, the 8th century philosopher.
- **Mahasamadhi** — a yogic practice in which highly advanced spiritual seers/practitioners are understood to voluntarily relinquish the physical body through higher meditative practices. e.g., Swami Vivekananda, Paramahansa Yogananda, and Ramana Maharshi.
- **Santhara / Sallekhana** — a religiously sanctioned Jain community vow of gradual, voluntary reduction of food and liquids to approach death, historically and socio-legally treated as an act of spiritual purification rather than suicide. e.g., Chandragupta Maurya, the founder of Maurya Empire, Acharya Bhadrabahu.

The High Court of Rajasthan in *Nikhil Soni v. Union of India (Raj. HC, 2015)* declared this practice to be illegal and punishable as suicide. The Jain scholars have asserted that suicide stems from despair, depression, passion, or anger whereas Santhara is a deliberate, calm, and voluntary pursuit of spiritual purification and liberation. Following an appeal, the Supreme Court stayed the High Court ruling.

These traditions are not being cited to romanticise the inevitability of death but to make a point that the constitutional recognition of dignity in dying was not an imported concept grafted onto an unwilling legal mindset. It drew on an indigenous vocabulary of autonomy



over one's own end, a point the Supreme Court itself makes when it distinguishes the "natural culmination" of life from its unnatural termination.



SUICIDE VERSUS EUTHANASIA – THE DISTINCTION

The single most common confusion in public discourse and the one this article attempts to resolve before going further is the conflation of suicide with euthanasia. The two are treated as legally, medically and morally distinct under Indian law and the entire architecture of Common Cause and Harish Rana judgments by the Apex Court rests on keeping that distinction intact.

i) Suicide

Suicide is the deliberate, self-inflicted act by which a person ends his or her own life, ordinarily out of despair, mental illness, or acute personal crisis and without any medical justification of terminal illness. Attempting suicide was, until recently, a criminal offence under Section 309 IPC (now substantially decriminalised in effect for persons under severe stress via Section 115 of the Mental Healthcare Act, 2017) and abetting another's suicide remains a serious offence under Section 306 IPC / Section 108 BNS.

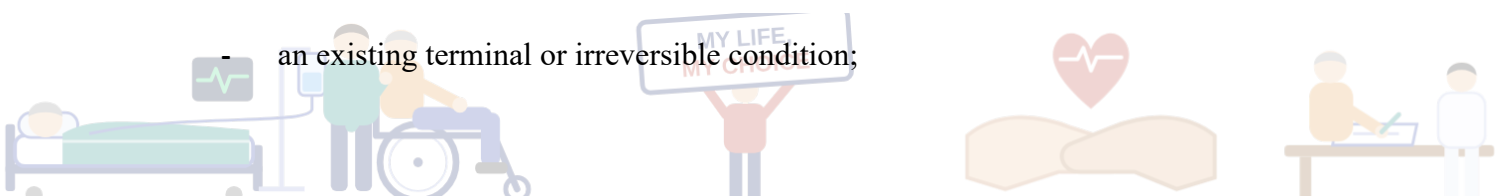
Suicide involves no third party administering or withdrawing treatment, no medical board, no judicial sanction and critically no underlying terminal or irreversible medical condition that would otherwise cause death. It is, in law, viewed as a tragedy to be prevented, not a right to be facilitated on any ground.

ii) Euthanasia

Euthanasia (from the Greek eu, "good," and thanatos, "death") refers to a deliberate intervention undertaken, with appropriate medical and where applicable, *judicial oversight*, to end or permit the ending of the life of a person already suffering from a terminal or irreversible medical condition, in order to relieve otherwise unrelievable pain and indignity.

Unlike suicide, euthanasia presupposes:

- an existing terminal or irreversible condition;



- medical board assessment of futility;
- a structured, supervised process; and
- in India's non-voluntary cases, family and institutional participation rather than a solitary, unsupervised act.

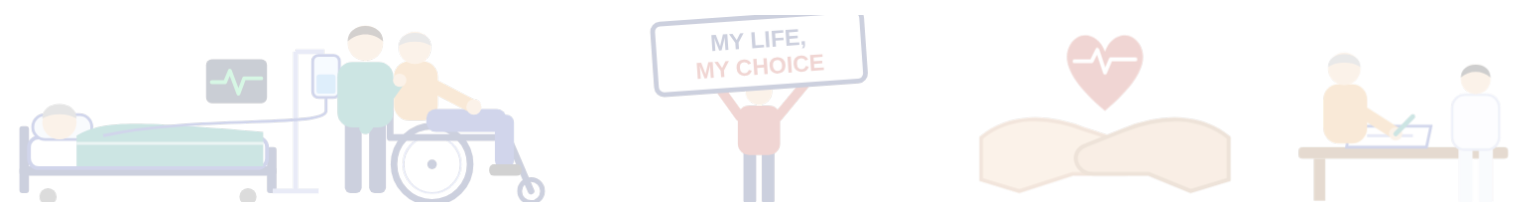
iii) Why the Distinction Matters

The Supreme Court in *Gian Kaur* (1996) case refused to read a general “right to die” into Article 21 of our Constitution because such a right, framed broadly, would be indistinguishable from a constitutional licence for suicide.

What the Court instead recognised and what Common Cause and *Harish Rana* judgments later built upon is a narrower and more defensible proposition, *that a person already dying of an irreversible medical condition has a right not to have that dying process artificially and painfully prolonged. Suicide accelerates death in a person who is not otherwise dying; passive euthanasia declines to artificially delay death in a person who already is.*

The “Source of Harm” test laid down in *Harish Rana* case captures this precisely; suicide (like active euthanasia) introduces a new causative agent that itself brings about death, whereas withdrawal of treatment merely removes an artificial barrier and lets an existing fatal condition run its course. This is the conceptual line that keeps India's end-of-life jurisprudence from collapsing into a general right to die and it is the line every subsequent section of this article assumes.

The “Best Interest of the Patient” principle, also laid down in *Harish Rana* case, supplies the second half of this line; where the Source of Harm test establishes that withdrawal of treatment is a lawful omission and not an act of killing, the best interest principle asks whether, for this particular patient, continued treatment still serves any genuine purpose. Where the patient cannot decide for himself, the question is not what the family or the doctors wish, but what is truly best for the patient as a whole person – medically, socially and emotionally. Together the two tests keep withdrawal lawful in its nature and justified in its purpose.



iv) Categories/Types of Euthanasia and Their Legal Status in India

Euthanasia is not a single, undifferentiated act — it is a family of distinct practices, classified along two independent axes: **(a)** how death is brought about (active vs. passive), and **(b)** whose consent drives the decision (voluntary, non-voluntary, or involuntary). Taken together, these give six commonly discussed categories, of which only passive euthanasia (withdrawal of treatment) is currently lawful in India.

Type	What It Means	Legal in India?
Active Euthanasia	A doctor or third party takes a deliberate, affirmative step such as administering a lethal injection that itself directly causes death.	✗ Illegal — culpable homicide/murder under ss.100–105 BNS.
Passive-Euthanasia (The withholding or withdrawal of life-sustaining treatment)	Life-sustaining treatments (such as a ventilator, or clinically assisted nutrition and hydration (CANH) are withheld or withdrawn, letting the underlying fatal condition take its natural course.	✓ Legal — Common Cause (2018) and Harish Rana (2026).
Voluntary Euthanasia	Performed at the competent patient’s own express request (via Living Will).	🕒 Legal only in its passive form, Per a valid Advance Medical Directive.
Non-Voluntary Euthanasia	Patient is medically incapable of consenting, being in Persistent Vegetative State (PVS); decision rests on a “best interests” test by doctors and family.	🕒 Legal only in its passive form, as applied in the Harish Rana matter.
Involuntary Euthanasia	Life is ended against the express wish or without seeking the wish of a patient capable of deciding.	✗ Illegal in every form — treated as murder.
Physician-Assisted Suicide	A doctor provides the means (e.g., a prescription) for the patient to end their own life; the patient, not the doctor, performs the final act.	✗ Illegal — abetment of suicide under s.306 IPC / s.108 BNS.

Stripped to its essentials, India currently permits exactly one practice on this matrix: passive euthanasia, whether voluntary (patient-directed via a Living Will) or non-voluntary (family- and Board-directed, as in Harish Rana case).

Active euthanasia, involuntary euthanasia, and physician-assisted suicide remain criminal offences without exception, regardless of the patient’s suffering, consent, or prognosis.





THE PRE-LEGALISATION ERA: CRIMINALISATION AND JUDICIAL HESITATION

Until judicial intervention reshaped the field, Indian statutory law treated any intentional curtailment of human life — irrespective of medical terminality, irreversibility, or the intensity of suffering involved — as a criminal offence.

i) The Statutory Framework

Active Euthanasia and Assisted Suicide: The administration of a lethal substance to terminate life constituted culpable homicide or murder under Sections 299–304 of the Indian Penal Code, 1860 (now Sections 100–105 of the Bharatiya Nyaya Sanhita, 2023). Physician-assisted suicide fell within IPC Section 306 (BNS Section 108), abetment of suicide.

Attempted Suicide: Section 309 IPC made any attempt on one's own life a punishable offence — a provision retained, controversially, even after Common Cause (2018), and substantially narrowed only by Section 115(1) of the Mental Healthcare Act, 2017, which presumes severe stress rather than criminal intent where the person has a mental illness.

ii) Early Judicial Precedents Leading to Divergence

***P. Rathinam v. Union of India* (1994) 3 SCC 394:** A Division Bench of the Supreme Court struck down Section 309 IPC as unconstitutional, reasoning that the “right to life” under Article 21 logically extends to a “*right not to live a forced life.*”

***Gian Kaur v. State of Punjab* (1996) 2 SCC 648:** A 5-judge Constitution Bench overruled Rathinam and upheld Sections 306 and 309 IPC, holding that the “right to life with dignity” under Article 21 does not carry within it a free-standing “right to die.” Critically, however, the Bench left open a narrow, prospective exception: it observed that *a terminally ill patient in a state of unbearable pain, nearing a natural death, might represent a distinct category in which artificial prolongation of the dying process – as opposed to life itself – could permissibly be withdrawn.* This single paragraph became the basis from which the concept of the withholding or withdrawal of medical treatment (earlier known as passive euthanasia) jurisprudence has grown.



iii) The Law Commission of India's Intervention in 2006

Well before the Courts revisited the issue, the Law Commission of India had already begun laying normative groundwork. Its 196th Report titled, “Medical Treatment to Terminally Ill Patients (Protection of Patients and Medical Practitioners) (2006)”, drew a sharp conceptual line between “mercy killing” and the withdrawal of treatment that merely prolongs the process of dying, characterising the latter as a lawful omission rather than an unlawful act. This distinction, between actively causing death and passively declining to artificially defer it also paved way for liberal judicial intervention on the subject.



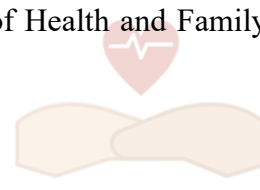
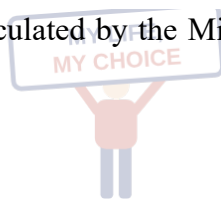
THE JUDICIAL EVOLUTION: FROM ARUNA SHANBAUG TO COMMON CAUSE II

i) Aruna Ramachandra Shanbaug v. Union of India (2011) 4 SCC 454

Aruna Shanbaug, a hospital nurse subjected to a brutal sexual assault in 1973, remained in a Persistent Vegetative State (PVS) for nearly four decades. Her case gave the Supreme Court its first occasion to translate the Gian Kaur exception into operative law. While dismissing the writ petition seeking Aruna be allowed to die peacefully holding that the petitioner had no locus standi in the matter, the Court permitted passive euthanasia for PVS patients for the first time in Indian legal history, holding that withdrawal of life support was permissible, but only subject to prior High Court approval under Article 226 and the concurrence of a three-doctor medical board.

ii) The 241st Law Commission Report (2012)

Responding to the Supreme Court's own request in Aruna Shanbaug for legislative clarity, the 17th Law Commission's 241st Report, titled 'Passive Euthanasia — A Relook' (August 2012), revisited its earlier 196th Report and proposed a redrafted Bill. The Report endorsed passive euthanasia on humanitarian grounds, sought statutory protection for doctors acting bona fide in a patient's best interest and classified passive euthanasia into voluntary (where patient consent is available) and non-voluntary (where the patient's incapacity makes consent unattainable) categories — a taxonomy the courts would later adopt wholesale. Despite this, and despite a 2016 draft Bill circulated by the Ministry of Health and Family Welfare for

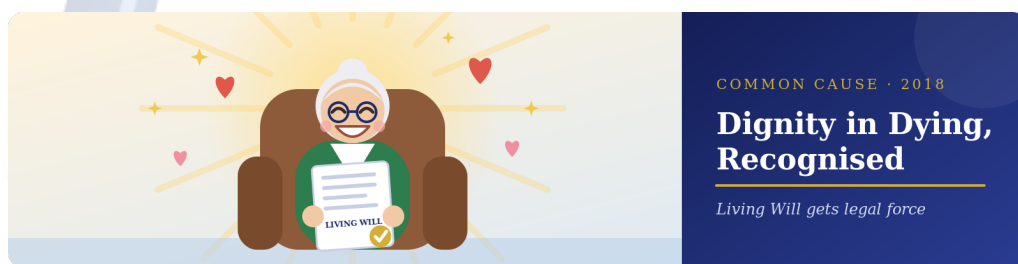


public comment, Parliament has, as of today, still not enacted a standalone statute on the subject.

iii) Common Cause v. Union of India (2018) 5 SCC 1

A five-judge Constitution Bench, speaking through Dipak Misra, C.J., delivered the watershed ruling: the right to die with dignity was declared an inseparable facet of the fundamental right to life under Article 21 and *Advance Medical Directives* (living will) were given the force of law for the first time in India.

The right to life with dignity under Article 21 of the Constitution encompasses the right to die with dignity. Withholding or withdrawing futile medical treatments does not constitute abandonment or suicide; rather, it respects bodily integrity and allows the natural process of death to occur without prolonged, artificial distress.



Yet the procedural architecture the Bench prescribed proved almost unworkable in clinical practice:

- Living Wills required execution before two attesting witnesses and mandatory countersignature by a Judicial Magistrate First Class (JMFC).
- The executed directive had to be lodged in the physical custody of the District Court.
- The Primary Medical Board required doctors of twenty years' standing; the Secondary Board had to be externally constituted by the District Collector, introducing a layer of bureaucratic delay entirely oblivious to a clinical emergency.
- No outer time limit was fixed for the Boards to decide, leaving families in indefinite limbo.

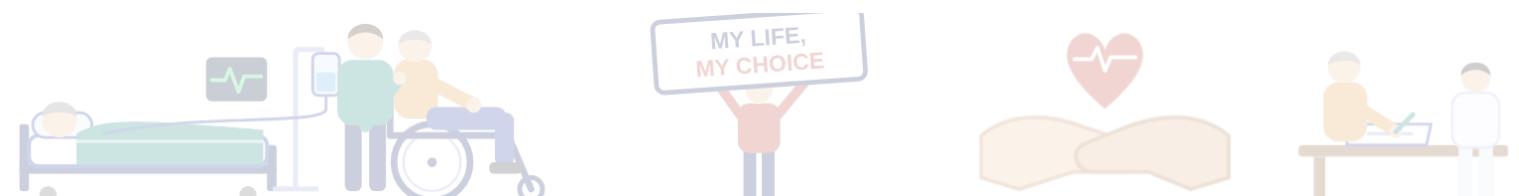
Studies conducted between 2018 and 2022 recorded a small number of Living Wills actually registered nationwide, precisely because the 2018 machinery imported a court-centric, property-Will model onto a medical-emergency context, making it overwhelming for common adoption.



iv) The 2023 Procedural Modifications (Common Cause II) – 2023 SCC OnLine SC 99

Recognising that its own 2018 guidelines were clinically unworkable, the Supreme Court, exercising its jurisdiction on a modification application moved by the Indian Society of Critical Care Medicine, drastically simplified the framework:

- **Attestation Reform:** Living Will signed in presence of two witnesses, attestation before a Notary Public or a Gazetted Officer was made sufficient. The witnesses and the notary or gazetted Officer shall record their satisfaction that the document has been executed voluntarily and without any coercion, inducement or compulsion and with full understanding of all the relevant information and consequences.
- **Streamlined Medical Boards:** The Primary Board was reduced to three doctors (the treating physician plus two specialists of five years' standing); the Secondary Board with minimum three members was to be constituted directly by the hospital, not an external district authority.
- **Strict Time Window:** Both Boards were required to record their decision within a mandatory 48-hour window of formation.
- **Custody and Digital Records:** Directives could now be lodged with local municipal custodians and integrated into electronic health records, rather than a district court registry.
- **Minimal Judicial Intervention:** Now there are two circumstances in which a Court intervention is envisaged. First, in cases where the primary medical board opposes the withdrawal or withholding of medical treatment and secondly, in cases where the secondary medical board does not concur with the opinion of the primary medical board to withdraw or withhold medical treatment. In such circumstances, the nominee of the patient, the family member, the treating physician, or the hospital staff may approach the High Court under Article 226 of the Constitution of India, in which case the Chief Justice of the said High Court shall constitute a division bench which shall decide to grant approval of not.





2018 vs 2023 AT A GLANCE

Aspect	Common Cause (2018)	Common Cause II (2023)
Attestation	Two witnesses + JMFC countersignature	Two Witnesses + Notary Public or Gazetted Officer
Custody	Physical custody of the District Court	Local municipal custodians + electronic health records
Primary Board	Doctors of twenty years' standing	Treating physician + two specialists (five years' standing)
Secondary Board	Externally constituted by the District Collector	Constituted directly by the hospital with three members.
Time limit	None fixed; families left in limbo	Mandatory 48-hour window



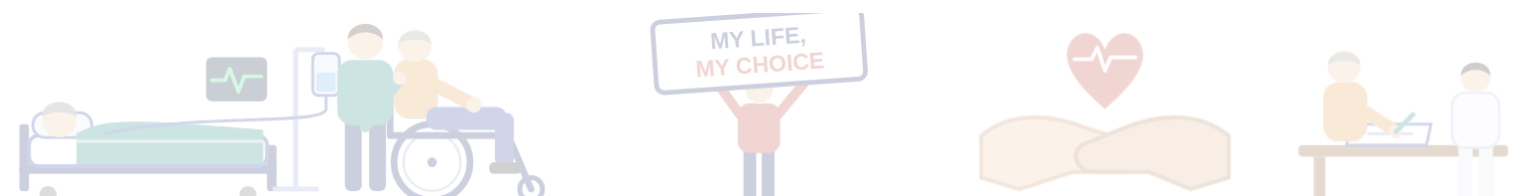
THE BENCHMARK DECISION: HARISH RANA V. UNION OF INDIA (2026 INSC 222)

Decided on 11 March 2026 by a Division Bench of Justices J.B. Pardiwala and K.V. Viswanathan (Miscellaneous Application No. 2238 of 2025 in SLP (C) No. 18225 of 2024 also reported as 2026 SCC OnLine SC 358)

Harish Rana is the first reported case in Indian legal history in which the simplified Common Cause II 2023 framework was applied end-to-end to authorise an actual, completed withdrawal of life-sustaining treatment.

HARISH RANA AT A GLANCE

~ 13 yrs in Persistent Vegetative State	11 Mar 2026 Judgment delivered by the Supreme Court	7 doctrinal rulings established	24 Mar 2026 Passed away peacefully at AIIMS
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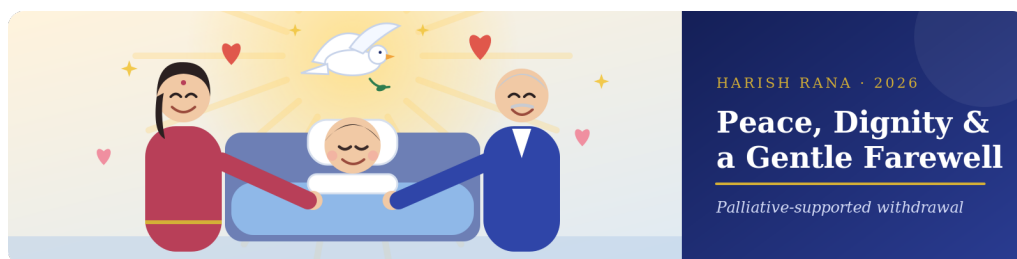


i) Facts Briefly

In August 2013, Harish Rana, then an 18-year-old B.Tech student at Punjab University, suffered a catastrophic fall from a fourth-floor accommodation sustaining severe diffuse axonal brain injury. He survived, but with total and permanent physical disability and in a Persistent Vegetative State that persisted for nearly thirteen years. He was sustained through a Percutaneous Endoscopic Gastrostomy (PEG) tube, tracheostomy, and catheter care, administered at home by his elderly parents, with no discernible environmental awareness. His writ petition before the Delhi High Court was dismissed in July 2024 on the erroneous ground that CANH administered through a PEG tube was “basic” rather than “mechanical” life support and therefore fell outside the Common Cause framework, an error the Supreme Court corrected decisively.

In giving permission to stop the treatment, the Supreme Court shifted the focus to a simple question: *"What is truly best for the patient?"* The Court ruled that looking out for a patient's best interest goes far beyond just medical facts. It means looking at the patient as a whole person—socially and emotionally. Doctors and families must face the hard truth and judge whether painful medical tubes are actually helping the patient or if they are just using machines to trap an unconscious person in a life without hope or dignity.

Harish Rana passed away peacefully on 24 March 2026 at the AIIMS Palliative Care Unit, New Delhi — thirteen days after the judgment and nearly thirteen years after the accident that placed him in PVS. Following the structured, phased withdrawal of CANH, his family donated his corneas and heart valves, making him the first individual in Indian history to undergo a fully court sanctioned, medically executed withdrawal of life-sustaining treatment.



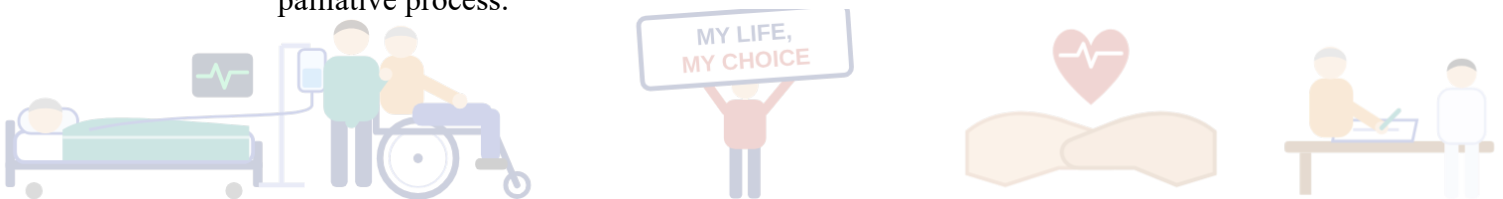
ii) The Doctrinal Rulings Established in the Harish Rana Judgment:

- a) **CANH is “Medical Treatment”:** The Court held explicitly that Clinically Assisted Nutrition and Hydration — whether delivered via a PEG or Ryle’s tube, and even when administered at home by lay caregivers — constitutes medical treatment requiring



clinical judgment and is therefore legally capable of withdrawal. This overruled the Delhi High Court's characterisation of CANH as mere "basic care".

- b) **The "Best Interest of the Patient" Principle:** Complementing the Source of Harm test, the Court held that where a patient cannot decide for himself, the decision to withhold or withdraw treatment must rest on what is truly best for the patient, judged on the patient as a whole person – medically, socially and emotionally – and not on medical facts alone. The Court introduced a practical "balance sheet" or a list of pros and cons for decision-makers. On one side is the natural desire to keep a person alive. On the other side is the painful reality of a treatment that cannot cure the patient, involves invasive tubes, and hurts their human dignity. The Court made it clear that if the tubes are only stretching out the dying process and causing indignity, the best and most compassionate choice for the patient is to let them go.
- c) **Abandonment of the Term "Passive Euthanasia":** The Court declared the expression "passive euthanasia" imprecise and conceptually obsolete, holding that it invites confusion with active, unlawful killing. It directed that courts and medical practitioners instead use the phrase "*withholding or withdrawal of medical treatment.*"
- d) **The "Source of Harm" Test:** The Bench articulated a new analytical test to distinguish lawful withdrawal from unlawful killing — active euthanasia introduces a new, external causative agent that itself brings about death, whereas withdrawal of treatment merely removes an artificial barrier and permits the patient's underlying fatal medical condition to run its natural course.
- e) **Primacy of Concurring Medical Boards:** Where the Primary and Secondary Medical Boards unanimously agree on irreversibility and the futility of continued treatment, their clinical judgment directly determines the outcome, without an invariable requirement of prior court approval in every case — a significant procedural acceleration from the guidelines laid out in Aruna Shanbaug case.
- f) **Right to Quality Palliative Care as Inseparable from Article 21:** The Court held that the right to die with dignity is structurally inseparable from a correlative right to quality palliative care. The withdrawal of treatment, the Court cautioned, must never be an abrupt act of abandonment, but a phased, pain-free, clinically supervised palliative process.



- g) **A Protocol for Home-Based Patients:** Recognising that a large proportion of India's PVS patients — unlike in wealthier jurisdictions — are cared for at home rather than in ICUs, the Bench laid down an operational protocol bridging a critical procedural gap left open by the 2018 and 2023 guidelines.
- h) **Independent Constitutional Basis for Non-Voluntary Withdrawal for Incompetent Patients:** If a patient cannot speak or decide (including where there is no Living Will), the Court cannot use “choice” as a justification. Instead, the Court bases the decision on Article 21 of the Indian Constitution, specifically the rights to human dignity and bodily integrity.



CRITICAL ANALYSIS: UNRESOLVED GAPS IN THE HARISH RANA FRAMEWORK

A few structural weaknesses remain even after Harish Rana judgment and merit sustained academic, administrative and legislative attention:

i) The Persisting Legislative Vacuum

Despite two express Supreme Court appeals to Parliament — in Common Cause (2018) and again in Harish Rana (2026) — India continues to regulate end-of-life decision-making entirely through judicially framed guidelines rather than a parliamentary statute.

The series of private member bills “Introduction of The Euthanasia (Regulation) Bill, 2002” by Shri Uttam Rao Dhikale in Lok Sabha on 21.02.2002; “Introduction of The Euthanasia (Permission and Regulation) Bill, 2007” by Shri C. K. Chandrappan in Lok Sabha on 24.07.2007; “Introduction of The Euthanasia (Regulation) Bill, 2014” by Shri Bhartruhari Mahtab in Lok Sabha on 12.12.2014 and reintroduced on 26.07.2019 highlights decades-long attempt by individual Indian parliamentarians to legally define and regulate the right to die with dignity, pushing boundaries well before mainstream government legislation. The Medical Treatment of Terminally-Ill Patients (Protection of Patients and Medical Practitioners) Bill, 2016 proposed by the Union Ministry of Health and Family Welfare (MoHFW) to regulate passive euthanasia in India faced significant backlash from health experts, legal think-tanks and advocacy groups.



The guidelines issued by the Supreme Court of India under Article 142 lack the certainty, enforceability, and democratic legitimacy of legislation, and remain vulnerable to inconsistent interpretation by trial courts, medical boards, and hospital administrators who are, in the ordinary course, unfamiliar with the nuances of adjudication.

ii) Absence of a Centralised Digital Registry

Common Cause II (2023) judgment permitted custody of Living Wills with local municipal officers and integration into electronic health records, yet Harish Rana leaves untouched the absence of a unified, interoperable national portal. A Living Will executed in Mumbai remains invisible to a treating doctor confronting a medical emergency in Delhi, a gap that converts a constitutional right into a geographically contingent privilege.

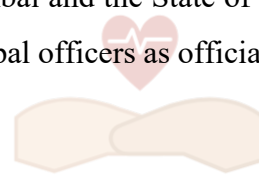
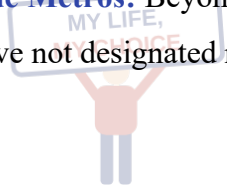
iii) Under-Development of Palliative Care Infrastructure

The Court's insistence that withdrawal be accompanied by "quality palliative care" is doctrinally sound but empirically aspirational. India's palliative care coverage remains heavily concentrated in AIIMS-model institutions and pioneering states such as Kerala, leaving large rural and peri-urban populations without the very infrastructure the judgment presupposes as a precondition for lawful withdrawal.



GROUND REALITY: IMPLEMENTATION IN INDIA TODAY

- a) **P.D. Hinduja Hospital's Living Will Clinic:** It clearly demonstrates how individual institutions can operationalise Supreme Court directives ahead of state machinery. P.D. Hinduja Hospital, Mahim, Mumbai, established India's first dedicated Living Will Clinic, a specialised clinic offering combined legal and medical counselling to citizens seeking to execute Advance Medical Directives (Living Will).
- b) **Brihanmumbai Municipal Corporation (BMC):** The BMC has designated municipal custodians across all administrative wards of Mumbai. To date, over fifty Living Wills have been formally registered and archived with these custodians, a meaningful indicator of rising civic awareness in a major urban centre.
- c) **Custodial Inaction Outside Metros:** Beyond Mumbai and the State of Maharashtra, most State governments have not designated municipal officers as official Living Will



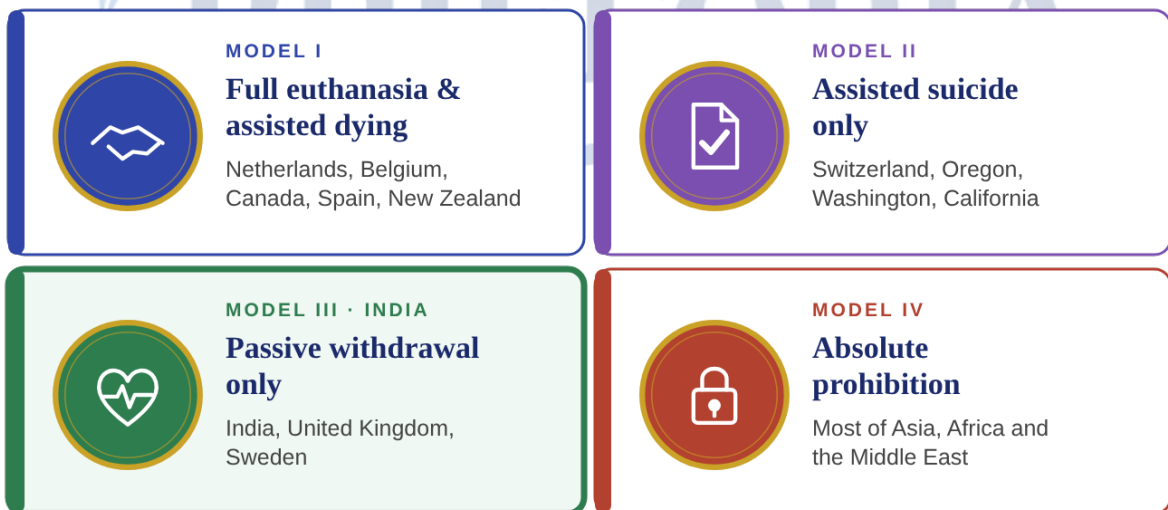
custodians, leaving Common Cause II's custody mechanism functionally dormant across most of India.

- d) **No Centralised EHR Portal:** In the continued absence of a national Living Will electronic portal, a directive executed in one city cannot be verified by treating doctors elsewhere during an actual emergency.
- e) **Societal/Familial Reluctance:** End-of-life choices remain subject to deep cultural taboo, and familial decision-making frequently overrides individually expressed patient autonomy at the moment of crisis.
- f) **Legislative Vacuum:** Despite repeated judicial calls in 2018 and 2026, introduction of private members bills in the Lok Sabha, an attempt to propose a draft regulation by the Union Ministry of Health and Family Welfare, the Parliament has not enacted a statute on end-of-life care, leaving the field entirely reliant on evolving judicial guidelines.

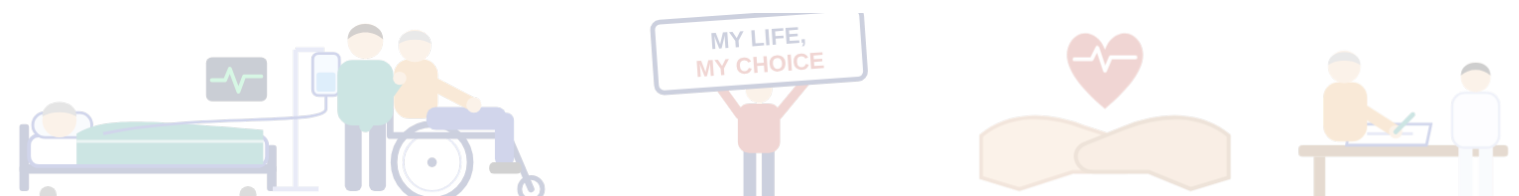


GLOBAL FRAMEWORK

Broadly, jurisdictions fall into four models:



- (i) *Full euthanasia and assisted-dying regimes permitting physician-administered death:*
The Netherlands, Belgium, Luxembourg, Canada, Colombia, Spain, New Zealand, and Australia.



- (ii) *Assisted-suicide-only regimes*, where the patient self-administers under medical prescription, including Switzerland and several States in the United States (Oregon, Washington, California, Colorado, Vermont, Montana, Hawaii);
- (iii) *Passive-withdrawal-only regimes*, where withdrawal of futile treatment is lawful but active euthanasia and assisted suicide remain criminal — the position India occupies, alongside Sweden and the United Kingdom; and
- (iv) *Regimes of continued absolute prohibition*, covering the majority of the world's states, including most of Asia, Africa, and the Middle East.

India's jurisprudence is deliberately conservative: it authorises only the withdrawal of futile treatment, never an act that itself causes death, and continues to criminalise both active euthanasia and physician-assisted suicide under the Bharatiya Nyaya Sanhita.

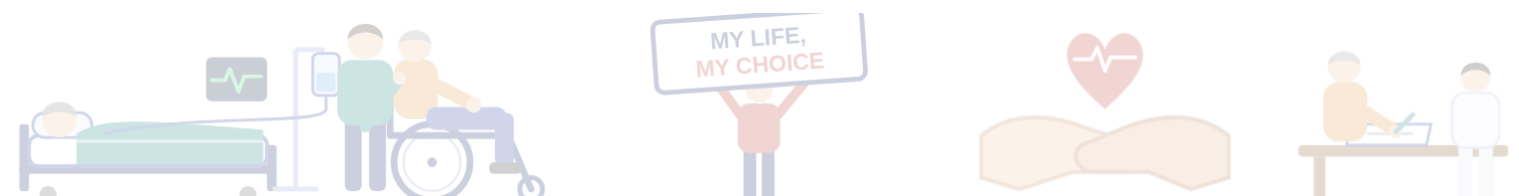


RECOMMENDATIONS FOR REFORM

In a nation marked by a colossal, predominantly rural population facing systemic illiteracy and inadequate medical infrastructure India must prioritise the implementation of *withholding or withdrawal of medical treatment* preventing it from becoming overly bureaucratic so that the right to a dignified death is accessible to the common citizen in simple, practical terms.

To achieve this sooner rather than later, a few steps are worthy of consideration as recommendations:

- a) **Enact a Standalone Parliamentary Statute:** Codify the Common Cause–Harish Rana framework into a dedicated End-of-Life Care and Advance Directives Act, removing reliance on Article 142 guidelines that lack the certainty of legislation.
- b) **Build a National Digital Living Will Registry:** Integrate advance directives with the Ayushman Bharat Digital Mission's health-ID architecture so that any treating doctor, anywhere in India, can verify a directive in real time.
- c) **Extend Municipal Custodianship Nationwide:** Mandate every urban local body and district administration to designate Living Will custodians within a fixed statutory timeline.



- d) **Invest in Palliative Care Infrastructure:** Expand AIIMS-model palliative care units to tier-2 and tier-3 cities, since the Harish Rana palliative mandate is meaningless without the capacity to deliver it.
- e) **Public Legal-Medical Literacy Campaigns:** Replicate the Hinduja Hospital Living Will Clinic model across government hospitals to counter the persistent societal taboo surrounding end-of-life planning.
- f) **Clarify the Family-Autonomy Interface:** Issue binding guidance on resolving disputes between a patient's previously expressed wishes and family's objections, to prevent families from acting without regard for the patient's actual wishes.



CONCLUSION

India's end-of-life jurisprudence has travelled a remarkable constitutional distance, from the absolute criminalisation of Section 309 IPC, through the cautious opening left by Gian Kaur, to the full doctrinal and clinical realisation achieved in Harish Rana v. Union of India.

The 2026 ruling is not merely another incremental refinement; it is the moment at which India's passive-withdrawal jurisprudence was for the first time tested against a real patient, a real family, and a real hospital, and shown to function. Yet a judgment, however carefully reasoned, cannot by itself build a national digital registry, train palliative care physicians, or dissolve deep-seated familial and societal reluctance to let go.

The next chapter of this jurisprudence will be written not in the Supreme Court, but in Parliament, in municipal corporations and in the quiet, difficult conversations that families have at hospital bedsides across the Country. Until that legislative and institutional infrastructure catches up with the constitutional doctrine, the right to die with dignity in India will remain, for the vast majority of its citizens, a right that exists more fully on paper than in practice. In closing, a well-known proverb perfectly fits the current situation;

“The best time to plant a tree was 20 years ago. The second best time is now.”



*“A right that exists more fully
on paper than in practice.”*

THE NEXT CHAPTER: PARLIAMENT AND PRACTICE

