Death with Dignity: Judicial Recognition and the Evolution of the Right to Die under Article 21 of the Constitution of India

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ABSTRACT

The Constitutional recognition of the Right to Die with Dignity has fundamentally reshaped the interpretation of Article 21 of the Constitution of India, raising a critical question: does the constitutional guarantee of life extend to protecting dignity at its natural end? While Indian constitutional jurisprudence has progressively embraced the values of human dignity, bodily autonomy, privacy and self-determination, the legal framework governing end-of-life decision-making continues to evolve through judicial intervention rather than legislative action. This paper examines the constitutional foundations of the Right to Die with Dignity and traces its judicial evolution through *P. Rathinam v. Union of India*[1], *Gian Kaur v. State of Punjab*[2], *Aruna Ramachandra Shanbaug v. Union of India*[3], *Common Cause v. Union of India*[4], *and Harish Rana v. Union of India (2026)* [5]. It analyses the constitutional principles of dignity, bodily autonomy, informed consent, privacy, constitutional morality and examines the legal distinction between active and passive euthanasia and the recognition of Advance Medical Directives; and evaluates the practical and institutional challenges that continue to affect the implementation of end-of-life rights. The study demonstrates that while judicial interpretation has firmly embedded the Right to Die with Dignity within Article 21, the absence of a comprehensive statutory framework continues to impede its uniform and effective enforcement. It concludes that meaningful constitutional protection requires a coherent legislative framework capable of harmonising constitutional guarantees, medical ethics, institutional accountability, and patient autonomy.

Keywords: *Right to Die with Dignity, Article 21, Passive Euthanasia, Human Dignity, Constitutional Jurisprudence, End-of-Life Rights.*

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[1] *P. Rathinam v. Union of India, (1994) 3 SCC 394 (India).*
[2] *Gian Kaur v. State of Punjab, (1996) 2 SCC 648 (India).*
[3] *Aruna Ramachandra Shanbaug v. Union of India, (2011) 4 SCC 454 (India).*
[4] *Common Cause v. Union of India, (2018) 5 SCC 1 (India).*
[5] *Harish Rana v. Union of India, 2026 SCC OnLine SC 358 (India).*

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CHAPTER I - INTRODUCTION

The Constitution of India is a living and dynamic document whose interpretation has continuously evolved to address changing constitutional aspirations and social realities. Among the fundamental rights guaranteed under Part III of the Constitution, Article 21 occupies a position of paramount importance by providing that "no person shall be deprived of his or her life or personal liberty except according to the procedure established by law".[6] Although initially interpreted in a narrow and procedural sense, the Supreme Court of India has progressively transformed Article 21 into the cornerstone of Indian constitutional jurisprudence, recognising within its ambit numerous substantive rights essential to preserving the dignity, liberty, and autonomy of every individual.[7]

The transformation of the Article 21 represents one of the most remarkable developments in Indian constitutional law. Beginning with *Maneka Gandhi v. Union of India,* the Supreme Court departed from the restrictive interpretation adopted in the case of *A.K. Gopalan v. State of Madras* and held that the "procedure established by law" must be fair, just and reasonable rather than arbitrary and oppressive.[8] This decision marked a constitutional shift from a formal understanding of the concept of personal liberty to substantive conception of fundamental rights, enabling Article 21 to emerge as the principal source of several derivate rights, including the rights to health, livelihood, shelter, education, privacy, reproductive autonomy, and a clean environment. Consequently, the constitutional guarantee of life came to signify not merely physical existence but a life lived with dignity, self-respect, and meaningful autonomy.[9]

Human dignity has emerged as the normative foundation of Article 21. The Supreme Court has consistently recognised that dignity constitutes the essence of all fundamental rights and forms the constitutional basis for protecting individual autonomy and personal liberty.[10] In *Justice K.S. Puttaswamy (Retd) v. Union of India,* the Court reaffirmed that dignity, privacy and autonomy are inseparable constitutional values that collectively define the scope of Article 21.[11] This expanded the entire understanding of the constitutional liberty, which has profoundly

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[6] *INDIA CONST. art. 21.*
[7] *Maneka Gandhi v. Union of India, (1978) 1 SCC 248, 45 (India).*
[8] *A.K. Gopalan v. State of Madras, AIR 1950 SC 27, 15 (India); Maneka Gandhi v. Union of India (1978) 1 SCC 248, 50 (India).*
[9] *M.P. Jain, Indian Constitutional Law (8th ed. 2018).*
[10] *V.N. Shukla, Constitution of India (Mahendra Pal Singh & Nishant Awasthi eds., 14th ed. 2023).*
[11] *Justice K.S. Puttaswamy (Retd.) v. Union of India, (2017) 10 SCC 1, 100 (India).*

influenced several branches of law, including reproductive rights, medical jurisprudence, informed consent, and end-of-life decision-making.

Advances in modern medical science have fundamentally altered the legal understanding of life and death. The availability of ventilatory support, artificial nutrition, life-support systems, and intensive medical interventions has enabled life to be prolonged even where recovery is medically impossible.[12] While these technological developments have transformed healthcare, they have simultaneously generated complex constitutional, ethical, and legal questions concerning the continuation or withdrawal of life-sustaining treatment, patient autonomy, informed consent, and the responsibilities of medical professionals.[13] These developments have compelled constitutional courts across the world to reconcile the State's interest in preserving life with the equally important obligation to respect the dignity and autonomy of terminally ill patients.[14]

Within this constitutional framework, the Right to Die with Dignity has emerged as one of the most debated issues in contemporary Indian constitutional jurisprudence. The debate does not concern the recognition of an unrestricted right to terminate one's life, rather it concerns whether an individual possesses the constitutional right to refuse life-prolonging medical treatment and to permit the natural process of death where continued medical intervention merely prolongs suffering without any reasonable prospect of recovery.[15] The issue herein lies at the intersection of constitutional law, medical jurisprudence, bioethics, human dignity, and public policy, requiring courts to balance the sanctity of life against the principles of self-determination, bodily autonomy, and informed consent.

The judicial evolution of Right to Die in India reflects a gradual yet significant constitutional transformation. In the case of *P. Rathinam v. Union of India,* Supreme Court held that the Right to Life under Article 21 necessarily included the Right to Die, reasoning that the freedom to live with dignity also encompasses the freedom to end one's life.[16] However, this interpretation was subsequently overruled by a constitution bench in the case of *Gian Kaur v. State of Punjab,*

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[12] *LAW COMM'N OF INDIA, 196TH REPORT: MEDICAL TREATMENT TO TERMINALLY ILL PATIENTS (PROTECTION OF PATIENTS AND MEDICAL PRACTITIONERS) (2006).*
[13] *Indian Council of Medical Research, National Ethical Guidelines for Biomedical and Health Research Involving Human Participants, 146 (2017), https://ethics.ncdirindia.org/asset/pdf/ICMR_National_Ethical_Guidelines.pdf (last visited July 10, 2026).*
[14] *World Health Organization, Integrating Palliative Care and Symptom Relief into Primary Health Care (2018).*
[15] *LAW COMM'N OF INDIA, 241ST REPORT: PASSIVE EUTHANASIA - A Relook (2012).*
[16] *P. Rathinam, (1994) 3 SCC at 28 (India).*

which held that Right to Life could not be equated with Right to Die.[17] Nevertheless, the court introduced an important constitutional distinction by observing that the right to live with dignity may legitimately include the Right to Die with Dignity in the natural process of death, thereby laying the jurisprudential foundation for subsequent developments.

This constitutional foundation concept was considerably strengthened in the case of *Aruna Ramachandra Shanbaug v. Union of India,* wherein the Supreme Court recognised passive euthanasia under limited judicial supervision and prescribed safeguards governing the withdrawal of life-sustaining treatment.[18] The constitutional position was further clarified by the Constitution Bench in *Common Cause v. Union of India,* which unequivocally held that the Right to Die with Dignity forms and intrinsic part of Article 21 and recognised the legal validity of advance medical directives, commonly known as living wills.[19] The court emphasised that dignity, bodily integrity, privacy and informed consent are indispensable components of constitutional liberty and must continue to operate even at the final stages of life,

The recent decision of the Supreme Court in *Harish Rana v. Union of India (2026)* marks the latest and most significant development in this constitutional journey. Building upon the principles established in *Common cause,* the court revisited the procedural framework governing passive euthanasia and advance medical directives, reaffirmed the constitutional significance of dignity in end-of-life decision-making, and sought to simplify the implementation of judicial safeguards while preserving adequate protection against misuse. The judgement further reinforces that passive euthanasia does not involve intentionally causing death but permits the natural course of a terminal illness by withdrawing or withholding extraordinary life-sustaining treatment under carefully regulated conditions. [20]

Despite these progressive judicial developments, India continues to lack a comprehensive statutory framework governing passive euthanasia, advance medical directives, and end-of-life decision-making. The existing legal framework remains largely dependent upon judicial guidelines, resulting in procedural ambiguities, inconsistent implementation and uncertainty for patients, families, healthcare institutions, and medical practitioners. The absence of dedicated legislation also raises concerns regarding medical accountability, evidentiary standards, patient consent, and the protection of vulnerable individuals, thereby underscoring

[17] *Gian Kaur, (1996) 2 SCC at 13 (India).*
[18] *Aruna Ramachandra Shanbaug, (2011) 4 SCC at 50 (India).*
[19] *Common Cause, (2018) 5 SCC at 166 (India).*
[20] *Harish Rana, 2026 SCC OnLine SC 358, ¶ 53 (India).*

the need for a coherent statutory framework capable of translating constitutional principles into effective legal practice.

1.1 Statement of the Problem

The constitutional recognition of the Right to Die with Dignity has evolved primarily through judicial interpretation rather than legislative enactment. Although the Supreme Court has progressively expanded the scope of Article 21 to encompass human dignity, bodily autonomy, and end-of-life decision-making, the practical implementation of these constitutional principles remains uncertain. The absence of a comprehensive statutory framework governing passive euthanasia, living wills, and advance medical directives has created inconsistencies in the application of judicial safeguards and procedural requirements. Furthermore, the evolving jurisprudence raises significant constitutional, ethical, and medical concerns regarding patient autonomy, the responsibilities of medical practitioners, institutional accountability, and the potential for misuse. This study seeks to examine whether the existing judicial framework sufficiently protects the Right to Die with Dignity or whether comprehensive legislative intervention is necessary to ensure effective implementation and legal certainty.

1.2 Research Objectives

1. To examine the constitutional evolution of the Right to Die with Dignity under Article 21 of the Constitution of India.
2. To analyse the judicial interpretation of human dignity, bodily autonomy, personal liberty, and self-determination in the context of end-of-life decision-making.
3. To critically evaluate the principles laid down in *P. Rathinam v. Union of India*, *Gian Kaur v. State of Punjab*, *Aruna Ramachandra Shanbaug v. Union of India*, *Common Cause v. Union of India*, and *Harish Rana v. Union of India*.
4. To assess the adequacy and practicality of the judicial safeguards governing passive euthanasia and advance medical directives.
5. To examine the need for a comprehensive legislative framework regulating euthanasia and end-of-life rights in India.

1.3 Research Questions

1. Whether the Right to Die with Dignity forms an enforceable constitutional right under Article 21 of the Constitution of India.
2. How has the Supreme Court's interpretation of the Right to Die evolved through successive constitutional decisions?
3. Whether the existing judicial safeguards governing passive euthanasia adequately protect patient autonomy while preventing misuse.
4. What constitutional, ethical, and practical challenges continue to affect the implementation of end-of-life rights in India?
5. Whether India requires comprehensive legislation to regulate passive euthanasia and advance medical directives.

1.4 Hypothesis

It is hypothesised that although the Supreme Court has progressively recognised the Right to Die with Dignity as an integral component of Article 21 of the Constitution of India, the absence of a comprehensive legislative framework continues to create procedural ambiguities and implementation challenges. Consequently, judicial recognition alone is insufficient to ensure the effective protection and uniform enforcement of end-of-life rights, necessitating statutory intervention to provide legal certainty and institutional consistency.

1.5 Research Methodology

The present study adopts a doctrinal legal research methodology. The research is analytical and descriptive in nature and is based primarily on the examination of constitutional provisions, judicial decisions, statutory instruments, Law Commission Reports, and other authoritative legal materials relating to the Right to Die with Dignity. Primary sources include the Constitution of India, landmark judgments of the Supreme Court, and relevant legal instruments governing passive euthanasia and advance medical directives. Secondary sources comprise scholarly books, peer-reviewed journal articles, research papers, government reports, and credible online legal databases.

1.6 Research Plan / Tentative Chapterization

Chapter I – Introduction: This chapter introduces the research problem, objectives, research questions, hypothesis, methodology, and overall structure of the study.

Chapter II – Constitutional Foundations of the Right to Die with Dignity under Article 21: This chapter examines the constitutional principles underlying the Right to Die with Dignity, including the concepts of human dignity, personal liberty, bodily autonomy, self-determination, and the evolving interpretation of Article 21.

Chapter III – Evolution of the Right to Die Jurisprudence in India: This chapter traces the judicial evolution of the Right to Die through landmark decisions, including *P. Rathinam v. Union of India*, *Gian Kaur v. State of Punjab*, *Aruna Ramachandra Shanbaug v. Union of India*, and *Common Cause v. Union of India*, highlighting the gradual constitutional recognition of end-of-life rights.

Chapter IV – Judicial Recognition of the Right to Die with Dignity: An Analysis of *Harish Rana v. Union of India* (2026): This chapter critically analyses the facts, issues, reasoning, ratio decidendi, constitutional significance, and practical implications of the Supreme Court's decision in *Harish Rana v. Union of India* (2026).

Chapter V – Contemporary Challenges and the Future of End-of-Life Jurisprudence in India: This chapter examines the practical, ethical, constitutional, and legislative challenges associated with implementing the Right to Die with Dignity. It further analyses comparative international approaches and proposes reforms for a comprehensive statutory framework.

Chapter VI – Conclusion: This chapter summarises the principal findings of the study, evaluates the hypothesis, and offers recommendations aimed at strengthening India's legal framework governing the Right to Die with Dignity.

CHAPTER II – CONSTITUTIONAL FOUNDATIONS OF THE RIGHT TO DIE WITH DIGNITY UNDER ARTICLE 21

The Constitution of India embodies a transformative vision of governance founded upon the principles of liberty, equality and justice. Among the guarantees contained in the Part III, Article 21 has emerged as the cornerstone of Indian constitutional jurisprudence by protecting every person's right to life and personal liberty. Although the constitutional text provides that "no person shall be deprived of life or personal liberty except according to the procedure established by law", judicial interpretation has consistently expanded the scope of this text to include numerous substantive rights, indispensable to human existence and dignity.[21] This dynamic interpretation has enabled Article 21 to evolve from a procedural safeguard into the constitutional foundation of human dignity, personal autonomy, privacy, healthcare, reproductive choice, and more recently, the Right to Die with Dignity.

The expression "life" under Article 21 has never been confined to mere physical or biological existence. Instead, the Supreme Court has consistently recognised that constitutional protection extends beyond survival to encompass every condition necessary for ensuring a meaningful, dignified, and autonomous human existence.

The constitutional interpretation of Article 21 has undergone a remarkable evolution since the commencement of the Constitution. In *A.K. Gopalan v. State of Madras*[22], the Supreme Court adopted a narrow and literal interpretation by holding that Article 21 merely required the existence of a legally prescribed procedure before a person could be deprived of life or liberty. The court declined to examine whether such procedure was fair, reasonable or just, thereby treating Article 21 as an essentially procedural safeguard. This restrictive interpretation significantly limited the scope of fundamental rights during the early years of the constitutional adjudication and reflected a formalistic approach to constitutional interpretation.

A decisive transformation occurred with the landmark judgment in *Maneka Gandhi v. Union of India* [23], wherein the Supreme Court fundamentally redefined the constitutional meaning of Article 21. Rejecting the restrictive approach adopted in *A.K. Gopalan*, the Court held that any law affecting life or personal liberty must satisfy the constitutional requirements of fairness,

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[21] *Aishwarya Chourasia, The Right to Die with Dignity, Academy of Law Education & Competitions, https://www.alec.co.in/show-blog-page/the-right-to-die-with-dignity (last visited July 10, 2026) (on file with author).*
[22] *A.K. Gopalan v. State of Madras, AIR 1950 SC 27 (India).*
[23] *Maneka Gandhi, (1978) 1 SCC at 87 (India).*

reasonableness, and non-arbitrariness. The Court further recognised that Articles 14, 19, and 21 are interconnected and together constitute the "golden triangle" and must be interpreted harmoniously, thereby substantially enlarging the scope of constitutional protection available to individuals.[24] The judgment marked the beginning of the substantive due process doctrine in Indian constitutional law and laid the doctrinal foundation for recognising several unenumerated rights under Article 21. Constitutional scholars regard *Maneka Gandhi* as the turning point that transformed Article 21 into the repository of human rights jurisprudence in India.

The recognition of human dignity as the constitutional core of Article 21 represents one of the most significant developments in Indian constitutional jurisprudence. Although the Constitution does not expressly define dignity, the Supreme Court has repeatedly affirmed that dignity is inseparable from the guarantee of life and personal liberty. The concept signifies the intrinsic worth of every individual and requires that every person be treated with respect, equality, and compassion irrespective of physical condition, age, or social status. Human dignity therefore rejects the notion that constitutional protection is confined to the preservation of biological life alone.

The evolution of Article 21 reached a significant milestone in *Francis Coralie Mullin v. Administrator, Union Territory of Delhi*, wherein the Supreme Court held that the Right to Life includes the right to live with human dignity and all that accompanies a meaningful existence.[25] By recognising dignity as the constitutional core of Article 21, the Court shifted the focus from preserving mere biological existence to protecting the quality of human life. This understanding assumes particular importance in end-of-life situations, where advances in medical technology have made it possible to prolong biological life even in cases of irreversible suffering. Consequently, the constitutional inquiry extends beyond whether life should be preserved to whether such preservation respects the dignity of the individual.

The constitutional recognition of dignity necessarily gave rise to the principles of bodily autonomy and self-determination, which acknowledge that every competent individual possesses the authority to make decisions concerning his or her own body and medical treatment. In *Samira Kohli v. Dr. Prabha Manchanda*[26], the Supreme Court affirmed that informed consent is an indispensable component of personal liberty, recognising that medical

[24] *Mahendra Pal Singh & Nishant Awasthi, V.N. Shukla's Constitution of India (14th ed. 2023).*
[25] *Francis Coralie Mullin v. Administrator, Union Territory of Delhi, (1981) 1 SCC 608 (India).*
[26] *Samira Kohli v. Dr. Prabha Manchanda, (2008) 2 SCC 1 (India).*

treatment without valid consent infringes individual autonomy. The constitutional protection of personal choice was further reinforced in *Justice K.S. Puttaswamy (Retd.) v. Union of India*[27], where a nine-Judge Bench recognised privacy as an intrinsic part of Article 21, encompassing decisional autonomy and bodily integrity. These principles collectively establish that personal liberty includes the freedom to make intimate healthcare decisions without arbitrary State interference.

The constitutional evolution of Article 21 thus demonstrates a gradual movement from protecting life as mere existence to safeguarding life with dignity. Constitutional scholars and medical ethicists have similarly argued that respect for autonomy and dignity forms the ethical foundation of end-of-life decision-making.[28] The Law Commission of India has likewise recognised that respecting a competent patient's refusal of life-sustaining treatment reflects constitutional values of dignity rather than a denial of the sanctity of life.[29]Accordingly, the constitutional principles of dignity, autonomy, privacy, and self-determination collectively provide the normative foundation upon which the Supreme Court has developed the jurisprudence governing passive euthanasia and the Right to Die with Dignity.

[27] *Justice K.S. Puttaswamy (Retd.), (2017) 10 SCC at 300 (India).*
[28] *Tom L. Beauchamp, The Right to Die as the Triumph of Autonomy, 31 J. Med. & Phil. 643, 16 (2006); Suresh Bada Math & Santosh K. Chaturvedi, Euthanasia: Right to Life vs Right to Die, 136 Indian J. Med. Res. 899, 10 (2012).*
[29] *Law Comm'n of India, 241st Report: Passive Euthanasia - A Relook (2012).*

CHAPTER III – EVOLUTION OF THE RIGHT TO DIE JURISPRUDENCE IN INDIA

The constitutional recognition of the Right to Die with Dignity in India was neither immediate nor linear. Rather, it emerged through a gradual process of judicial interpretation spanning more than three decades, during which the Supreme Court reconsidered the relationship between the sanctity of life, personal liberty, human dignity, and individual autonomy. Initially, Indian criminal law treated any attempt to end one's life as an offence under Section 309 of the Indian Penal Code, 1860, reflecting the traditional view that the state possessed an overriding interest in preserving life. However, as constitutional jurisprudence under Article 21[30] expanded, the court increasingly recognised that the protection of life must also encompass the protection of dignity, particularly where an individual faces irreversible illness and unbearable suffering. The evolution of the jurisprudence can be understood by four landmark decisions, each of which significantly reshaped the constitutional understanding of end-of-life-rights.

The Supreme Court first directly considered whether the Constitution recognised a right to die in the case of *P. Rathinam v. Union of India*[31]. The court in this case struck down Section 309 of the IPC, which criminalised attempt to commit suicide. The petitioners argued that if Article 21 protects the right to live with dignity, it must also include the freedom to terminate one's own life. Court observed that the "right to life" necessarily included a corresponding "right not to live". The court reasoned that compelling a person to continue living against his or her wishes could, in certain circumstances, undermine the very dignity that Article 21 sought to protect. The Supreme Court also drew a parallel with other fundamental rights: just as the freedom of speech under Article 19 includes the right not to speak, the right to life under Article 21 includes the right not to live.[32]

Although *P. Rathinam* represented the first judicial attempt to constitutionalise the concept of a right to die, its reasoning attracted considerable criticism. The judgment failed to distinguish between suicide arising from transient emotional distress and decisions concerning terminal illness or irreversible medical conditions. Scholars argued that equating the right to live with a general right to die overlooked the State's legitimate interest in suicide prevention and mental

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[30] *INDIA CONST. art. 21.*
[31] *P. Rathinam, (1994) 3 SCC at 11 (India).*
[32] *Passive Euthanasia in India and the Right to Die with Dignity, Drishti IAS, https://www.drishtiias.com/daily-updates/daily-news-editorials/passive-euthanasia-in-india-and-the-right-to-die-with-dignity (last visited July 10, 2026).*

health protection.[33] Consequently, while the decision introduced the language of dignity into the constitutional debate, it did not provide a coherent constitutional framework for end-of-life decision-making.

The constitutional position was substantially reconsidered only two years later by a Constitution Bench in *Gian Kaur v. State of Punjab*[34]. The Court unanimously overruled *P. Rathinam* and upheld the constitutional validity of Section 309 IPC. Rejecting the proposition that Article 21 included an unrestricted right to die, the Court held that the right to life is a natural right whereas suicide constitutes an unnatural termination of life and therefore falls outside constitutional protection. According to the Court, Article 21 cannot be interpreted as conferring a positive right to extinguish life because such an interpretation would contradict the very object of the constitutional guarantee. The Supreme Court held that suicide and euthanasia are inconsistent with the concept of the right to life, as life is a natural and fundamental right. However, the Court also suggested that passive euthanasia, which allows patients to refuse life support, could be a valid option.[35] Although the Court declined to recognise euthanasia directly, its observations laid the constitutional foundation upon which future jurisprudence concerning passive euthanasia and advance medical directives would be built. Constitutional scholars widely regard this dictum as the conceptual bridge between the traditional sanctity-of-life doctrine and the later recognition of end-of-life rights.

The next major development occurred in *Aruna Ramachandra Shanbaug v. Union of India*, one of the most significant decisions concerning passive euthanasia in Indian legal history.[36] Aruna Shanbaug, a nurse who had remained in a permanent vegetative state for about thirty seven years following a brutal sexual assault, became the focal point of a public interest petition seeking permission for withdrawal of life-sustaining treatment. Although the Supreme Court ultimately declined to permit withdrawal in her specific case because the hospital staff wished to continue caring for her, the judgment fundamentally altered Indian law by recognising the legality of passive euthanasia under exceptional circumstances.[37]

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[33] Suresh B. Math & Santosh K. Chaturvedi, Euthanasia: Right to Life vs Right to Die, 136 Indian J. Med. Res. 899, 3 (2012).
[34] Gian Kaur, (1996) 2 SCC at 11 (India).
[35] Aishwarya Chourasia, The Right to Die with Dignity, Academy of Law Education & Competitions (Feb. 8, 2025), https://www.alec.co.in/show-blog-page/the-right-to-die-with-dignity (last visited July 10, 2026) (on file with author).
[36] Aruna Ramachandra Shanbaug, (2011) 4 SCC at 50 (India).
[37] R. Santhoshini & L. Sreeja, From Right to Life to Right to Die: A Critical Examination of Indian Constitutional Law, 13 Int'l J. Creative Rsch. Thoughts l92, 4 (2025).

Drawing extensively from comparative jurisprudence, particularly the decision of the House of Lords in *Airedale NHS Trust v. Bland* [38], the Supreme Court distinguished between active euthanasia, involving a deliberate act to end life, and passive euthanasia, involving the withdrawal or withholding of extraordinary life-sustaining treatment where continuation serves no therapeutic purpose. The Court held that passive euthanasia could be legally permissible subject to strict judicial supervision and directed that approval of the relevant High Court should be obtained before life-support measures could be withdrawn. Although these guidelines substantially advanced the recognition of patient autonomy and end-of-life rights, they also imposed complex procedural safeguards that frequently delayed urgent medical decisions and limited their effective implementation in clinical practice. Passive euthanasia remains legal in India under strict conditions following the rule laid in the following case of *Common Cause v. Union of India,* and active euthanasia remains illegal in India and is punishable under the Indian Penal Code.[39]

The constitutional recognition of the Right to Die with Dignity reached its most comprehensive expression in *Common Cause v. Union of India*[40]. Decided by a Constitution Bench, the judgment synthesised decades of constitutional jurisprudence on dignity, autonomy, privacy, and personal liberty to hold that the Right to Die with Dignity forms an integral component of Article 21. Relying upon the constitutional principles articulated in *Maneka Gandhi*, *Francis Coralie Mullin*, and *Justice K.S. Puttaswamy (Retd.)*, the Court concluded that preserving dignity during the process of dying is as constitutionally significant as protecting dignity throughout life. The Court emphasised that competent adults possess the autonomy to determine the course of their medical treatment and recognised that forcing futile medical intervention upon terminally ill patients may itself constitute an infringement of constitutional dignity.

Perhaps the most enduring contribution of *Common Cause* was the formal legal recognition of Advance Medical Directives, commonly known as Living Wills. The Court held that every competent individual possesses the constitutional authority to record, in advance, instructions regarding the refusal of life-sustaining treatment in circumstances where future incapacity renders direct communication impossible. Simultaneously, the Court declared passive euthanasia legally permissible and prescribed detailed procedural safeguards intended to

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[38] *Airedale NHS Trust v. Bland, [1993] AC 789, 15 (HL).*
[39] *Delhi Law Academy, Right to Die with Dignity | Article 21 of Constitution (Nov. 12, 2025), https://www.delhilawacademy.com/art-21-right-to-die-with-dignity-2/ . (last visited July 10, 2026).*
[40] *Common Cause, (2018) 5 SCC at 7 (India).*

prevent coercion, abuse, or arbitrary medical decision-making. Although these safeguards were later criticised as being excessively cumbersome, the judgment firmly established that constitutional values of dignity and autonomy continue to operate until the natural end of life.[41]

Collectively, these decisions demonstrate a gradual yet profound transformation in Indian constitutional jurisprudence. The Supreme Court moved from viewing the issue primarily through the lens of criminal law to recognising that end-of-life decisions implicate fundamental constitutional values of dignity, autonomy, privacy, and personal liberty. While *P. Rathinam* initiated the constitutional debate, *Gian Kaur* refined its doctrinal basis, *Aruna Shanbaug* introduced judicially regulated passive euthanasia, and *Common Cause* constitutionalised the Right to Die with Dignity under Article 21. Nevertheless, practical implementation remained hindered by procedural complexities, uncertainties surrounding Advance Medical Directives, and institutional barriers within the healthcare system. These concerns ultimately necessitated further judicial intervention, culminating in the Supreme Court's landmark decision in *Harish Rana v. Union of India (2026)*, which substantially simplified the procedural framework governing end-of-life rights.

[41] *Tom L. Beauchamp, The Right to Die as the Triumph of Autonomy, 31 J. Med. & Phil. 643, 8 (2006); Maggie Hendry et al., Why Do We Want the Right to Die? A Systematic Review of the International Literature on the Views of Patients, Carers and the Public on Assisted Dying, 27 Palliative Med. 13, 22 (2013).*

CHAPTER IV – JUDICIAL RECOGNITION OF THE RIGHT TO DIE WITH DIGNITY: AN ANALYSIS OF HARISH RANA v. UNION OF INDIA (2026)

The constitutional evolution of the Right to Die with Dignity in India attained a significant milestone with the Supreme Court's decision in *Harish Rana v. Union of India* (2026)[42]. While earlier decisions such as *Gian Kaur v. State of Punjab*, *Aruna Ramachandra Shanbaug v. Union of India*, and *Common Cause v. Union of India* progressively recognised dignity, autonomy, and self-determination as essential components of Article 21 of the Constitution, they primarily established the constitutional and normative foundations governing end-of-life decision-making. The practical implementation of these principles, however, remained uncertain. Questions continued to arise regarding the withdrawal of specific forms of life-sustaining treatment, the role of medical experts, and the extent to which procedural safeguards could accommodate exceptional circumstances. *Harish Rana* became the first reported decision in which the Supreme Court was required to apply the constitutional framework established in *Common Cause* to the circumstances of an individual patient. The judgment therefore represents a decisive transition from constitutional recognition to judicial implementation of the Right to Die with Dignity.

The significance of the decision lies not in recognising a new constitutional right but in clarifying the practical operation of an existing one. The Court reaffirmed that the Right to Die with Dignity forms an inseparable part of the Right to Life under Article 21 and clarified several important aspects of the law governing passive euthanasia. Most notably, it addressed the legal status of Clinically Assisted Nutrition and Hydration (CANH)[43], examined the constitutional distinction between preserving life and prolonging biological existence through medically futile treatment, and reaffirmed that dignity, autonomy, and compassion remain central constitutional values guiding end-of-life medical decisions. The judgment further demonstrated that procedural safeguards established in *Common Cause* are intended to protect patients rather than create inflexible procedural barriers that frustrate the exercise of constitutional rights.

The litigation arose from the tragic circumstances of Harish Rana, a young man who suffered catastrophic neurological injuries following a fall from the fourth floor of a balcony in 2013, which resulted in severe traumatic brain injury and irreversible neurological damage. The

[42] *Harish Rana v. Union of India, 2026 SCC OnLine SC 358 (India).*
[43] *Id.*

accident resulted in extensive and irreversible brain damage, leaving him permanently incapacitated and incapable of independent cognitive functioning. Medical evidence consistently established that he possessed no meaningful consciousness, no realistic prospect of neurological recovery, and remained entirely dependent upon artificial life-sustaining treatment for survival. His biological existence was sustained through Clinically Assisted Nutrition and Hydration (CANH), continuous nursing care, and intensive medical supervision. Repeated evaluations conducted by medical specialists unanimously concluded that the continuation of treatment would neither improve his condition nor restore any degree of cognitive awareness. Instead, continued medical intervention merely prolonged biological existence without offering any therapeutic benefit.

Faced with this prognosis, Harish Rana's father approached the Delhi High Court seeking permission to withdraw life-sustaining treatment in accordance with the constitutional principles recognised by the Supreme Court in *Common Cause v. Union of India*. The petition was carefully framed as a request for passive euthanasia through the withdrawal of medically futile treatment rather than active euthanasia or physician-assisted suicide. It was argued that compelling the continuation of treatment which no longer served any curative or therapeutic purpose violated the patient's constitutional right to live, and consequently to die, with dignity under Article 21. The petitioner contended that modern constitutional jurisprudence protects not merely biological existence but meaningful human dignity, and that where medical intervention merely prolongs the inevitable process of dying, the Constitution cannot require such intervention to continue indefinitely.

Although the Delhi High Court acknowledged that passive euthanasia had been constitutionally recognised by the Supreme Court in *Common Cause*, it declined to grant the requested relief. The principal difficulty before the High Court did not concern the legality of passive euthanasia itself but rather the legal character of Clinically Assisted Nutrition and Hydration. Unlike mechanical ventilation or other forms of intensive life support, artificial nutrition and hydration had historically occupied an uncertain position within medical jurisprudence. In several jurisdictions, the provision of food and water—even through artificial means—had traditionally been regarded as an aspect of ordinary nursing care rather than medical treatment. Consequently, the withdrawal of CANH raised complex ethical and legal concerns regarding whether such conduct merely permitted the natural process of dying or whether it actively caused death. In the absence of authoritative clarification from the Supreme Court, the Delhi

High Court considered it inappropriate to permit the withdrawal of CANH and therefore refused the relief sought by the petitioner.

Aggrieved by this decision, Harish Rana's father approached the Supreme Court under Article 136 of the Constitution. The appeal presented questions that extended well beyond the circumstances of an individual patient and required the Court to clarify several unresolved aspects of India's end-of-life jurisprudence. Unlike *Common Cause*, the Supreme Court was not required to determine whether the Right to Die with Dignity forms part of Article 21, as that issue had already been conclusively settled by the Constitution Bench in 2018. Instead, the Court was required to examine how the constitutional framework governing passive euthanasia should operate in practice when applied to an individual who lacked decision-making capacity and whose continued survival depended entirely upon artificial medical intervention.

The principal questions before the Court were therefore practical rather than theoretical. It was required to determine whether Clinically Assisted Nutrition and Hydration constitute life-sustaining medical treatment capable of lawful withdrawal or whether it forms part of ordinary care that must continue irrespective of the patient's prognosis. Closely connected to this question was whether withdrawing CANH amounts to passive euthanasia or whether it constitutes an act intentionally causing death. The Court was also required to consider whether withdrawal of such treatment would violate the constitutional obligation of the State to preserve life under Article 21 or whether, in appropriate circumstances, it would instead uphold the constitutional values of dignity and personal autonomy. Finally, the Court examined whether the procedural safeguards formulated in *Common Cause* had been substantially complied with and whether those safeguards could be interpreted flexibly where rigid adherence would only prolong medically futile treatment without advancing the interests of the patient.

The resolution of these issues necessarily required the Supreme Court to revisit the constitutional distinction between active and passive euthanasia. Although both arise in the context of terminal illness or irreversible medical conditions, Indian constitutional jurisprudence has consistently recognised that they differ fundamentally in their legal character and constitutional justification. Active euthanasia involves a deliberate and positive act intended to directly cause the patient's death, such as administering a lethal injection or another fatal substance. The immediate cause of death is therefore the intervention of another person. Since such conduct intentionally terminates life through an affirmative act, it continues to attract criminal liability and remains impermissible under Indian law. Neither *Common Cause*

nor *Harish Rana* questioned this settled legal position. The Supreme Court reaffirmed that Article 21 cannot be interpreted as conferring a constitutional right to actively terminate life, as such an interpretation would fundamentally undermine the State's constitutional obligation to protect life.

By contrast, passive euthanasia rests upon an entirely different constitutional foundation. Rather than introducing an external agency to cause death, it involves withholding or withdrawing medical treatment that merely prolongs biological existence without offering any realistic therapeutic benefit. In such situations, death results from the patient's underlying illness rather than from the physician's intervention. The constitutional legitimacy of passive euthanasia therefore derives not from any recognition of a general right to die, but from the constitutional commitment to dignity, bodily integrity, personal autonomy, and compassionate medical care. It was this distinction that formed the central constitutional issue before the Supreme Court in *Harish Rana*, ultimately requiring the Court to determine whether the withdrawal of Clinically Assisted Nutrition and Hydration could lawfully be characterised as permitting the natural process of dying rather than causing death itself.

One of the most significant contributions of the Supreme Court's decision lies in its clarification of the legal status of Clinically Assisted Nutrition and Hydration (CANH). Prior to *Harish Rana*, Indian constitutional jurisprudence had recognised the permissibility of withdrawing life-sustaining treatment through *Common Cause*, yet uncertainty persisted regarding whether artificial nutrition and hydration constituted ordinary care or medical treatment. This distinction was constitutionally significant because ordinary care ordinarily carries a continuing obligation of provision, whereas medical treatment may be lawfully withheld or withdrawn where it has become medically futile and no longer advances the interests of the patient. The absence of judicial clarity had resulted in hesitation among hospitals and medical practitioners, who feared potential criminal and professional liability if artificial nutrition or hydration were discontinued.

The Supreme Court resolved this ambiguity by holding that CANH constitutes life-sustaining medical treatment rather than ordinary nursing care. The Court observed that artificial nutrition and hydration are administered through specialised medical procedures involving feeding tubes, gastrostomy tubes, nasogastric tubes, intravenous systems, and continuous clinical supervision. Their administration requires professional medical assessment, monitoring, and periodic evaluation of the patient's condition. Consequently, CANH cannot be equated with the

ordinary act of providing food or water to a healthy individual. Instead, it represents an ongoing medical intervention intended to sustain biological functions where natural intake has become impossible. Once medical experts unanimously conclude that such intervention offers no therapeutic benefit and merely prolongs the biological process of dying, its withdrawal constitutes the discontinuation of medical treatment rather than the intentional termination of life. By recognising CANH as medical treatment, the Court substantially reduced legal uncertainty and aligned Indian constitutional jurisprudence with contemporary medical ethics and comparative common law principles.

In reaching this conclusion, the Supreme Court drew considerable support from comparative jurisprudence, particularly the decision of the House of Lords in *Airedale NHS Trust v. Bland*. That case concerned a young man who had remained in a persistent vegetative state following the Hillsborough Stadium disaster and whose survival depended entirely upon artificial nutrition and hydration. The House of Lords held that discontinuing life-sustaining treatment merely allowed the patient to die from the underlying medical condition rather than causing death through an affirmative act. Lord Goff explained that the legal significance of withdrawing treatment lies not in the physical act of removing medical equipment but in the omission to continue treatment that has become futile. Similarly, Lord Browne-Wilkinson observed that the removal of feeding tubes or other life-support systems should not be understood as actively causing death but as permitting the patient's underlying illness to take its natural course. The Supreme Court adopted this reasoning to reinforce the constitutional distinction between actively ending life and discontinuing treatment that no longer serves any therapeutic purpose. By incorporating these principles into the interpretation of Article 21, the Court strengthened the constitutional legitimacy of passive euthanasia while maintaining the prohibition against active euthanasia.

The judgment further addressed the philosophical tension between the sanctity of life and the quality of life, both of which occupy an important place within constitutional jurisprudence. The sanctity of life doctrine proceeds on the premise that every human life possesses intrinsic value and must therefore be preserved irrespective of illness, disability, or prognosis. This principle has traditionally informed constitutional interpretation by emphasising the State's duty to protect life against arbitrary deprivation. The Court recognised that this doctrine continues to constitute an essential component of Article 21 and cannot be disregarded merely because advances in medical science now permit life to be artificially prolonged.

At the same time, the Court observed that constitutional protection cannot be confined to biological survival alone. Modern medical technology has fundamentally altered the relationship between life and death by enabling patients suffering from irreversible neurological injuries or terminal illnesses to survive indefinitely through sophisticated life-support systems. While such interventions undoubtedly preserve physiological functions, they do not necessarily restore consciousness, autonomy, communication, or any meaningful quality of life. The Court therefore reaffirmed the principle first articulated in *Common Cause* that the constitutional guarantee of life derives its true meaning from dignity. Where continued treatment merely prolongs irreversible suffering or permanently maintains biological existence without any realistic possibility of recovery, compelling its continuation may undermine rather than preserve the constitutional values embodied in Article 21. The judgment thus rejected the proposition that every possible medical intervention must invariably continue regardless of its therapeutic value. Instead, it held that constitutional protection extends equally to ensuring that the process of dying occurs with dignity, compassion, and respect for human autonomy.

Closely connected with this reasoning was the Court's reaffirmation of patient autonomy as a central constitutional principle governing medical decision-making. The judgment recognised that every competent individual possesses the freedom to accept or refuse medical treatment, even where such refusal may ultimately result in death. This principle does not arise from a constitutional right to die but from the broader guarantees of personal liberty, bodily integrity, privacy, and decisional autonomy protected under Article 21. Medical treatment fundamentally concerns the human body, and the Constitution does not permit the State to compel unwanted medical intervention merely because such treatment has the capacity to prolong biological life. Where a patient lacks decision-making capacity, however, the exercise of autonomy necessarily assumes a different form. In such circumstances, substitute decision-making must occur through judicial supervision and expert medical evaluation to ensure that decisions reflect the patient's best interests while preventing abuse or arbitrary deprivation of life. The Court therefore emphasised that passive euthanasia remains subject to rigorous procedural safeguards precisely because the patient is unable to personally express informed consent.

Applying these constitutional principles to the facts before it, the Supreme Court carefully examined the reports prepared by successive medical boards constituted in accordance with the

framework prescribed in *Common Cause*[44]. The medical evidence unanimously established that Harish Rana had sustained irreversible neurological damage, lacked any meaningful cognitive awareness, and possessed no realistic prospect of recovery despite prolonged treatment. His continued survival depended entirely upon artificial life-sustaining intervention, particularly CANH. The medical boards further concluded that continuation of treatment would neither reverse his condition nor improve his quality of life but would merely prolong biological existence without therapeutic benefit. Having independently scrutinised the medical evidence, the Court was satisfied that the patient's condition satisfied the constitutional and medical requirements governing passive euthanasia.[45]

An equally important aspect of the judgment concerns the Court's interpretation of the procedural safeguards established in *Common Cause*. The Constitution Bench had formulated a detailed procedure involving multiple medical boards and judicial oversight in order to minimise the possibility of abuse while safeguarding vulnerable patients. In *Harish Rana*, however, the Supreme Court recognised that procedural safeguards should function as instruments for protecting constitutional rights rather than inflexible technical requirements capable of frustrating those very rights. Having regard to the unanimous medical evidence, the prolonged duration of litigation, and the irreversible condition of the patient, the Court waived the thirty-day waiting period ordinarily contemplated under the revised *Common Cause* guidelines. The Court observed that insisting upon additional procedural delays would serve no therapeutic purpose and would merely prolong medically futile treatment contrary to the patient's constitutional dignity. This aspect of the judgment demonstrates the Court's commitment to balancing procedural caution with practical compassion in exceptional cases.

Ultimately, the Supreme Court authorised the withdrawal of Clinically Assisted Nutrition and Hydration and permitted the discontinuation of further life-sustaining treatment. The ratio decidendi of the judgment may be summarised in four propositions. First, Clinically Assisted Nutrition and Hydration constitutes life-sustaining medical treatment capable of lawful withdrawal. Secondly, the withdrawal of such treatment amounts to passive euthanasia rather

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[44] *Dhvani Mehta, Rituparna Padhy & Shivani Mody, Harish Rana v. Union of India, Vidhi Ctr. for Legal Policy (Mar. 17, 2026), https://vidhilegalpolicy.in/research/harish-rana-v-union-of-india/ (last visited July 10, 2026) (on file with author).*

[45] *Prakshaal Jain, The Harish Rana Passive Euthanasia Case: Opinion Article, Indian Journal of Law and Legal Research, 5 (July 2, 2026), https://ijllr.com/post/the-harish-rana-passive-euthanasia-case-opinion-article (last visited July 10, 2026) (on file with author).*

than active euthanasia because it permits the underlying illness to take its natural course without introducing any external agency to cause death. Thirdly, passive euthanasia remains constitutionally protected under Article 21 where continued treatment has become medically futile and the procedural safeguards established by law are substantially satisfied. Finally, procedural requirements governing passive euthanasia should be interpreted purposively and may admit limited flexibility in exceptional circumstances where rigid adherence would defeat rather than protect constitutional dignity.

The constitutional significance of *Harish Rana* extends far beyond the circumstances of the individual case. By applying the principles recognised in *Common Cause* to an actual patient, the Supreme Court transformed a largely theoretical constitutional framework into a workable legal doctrine capable of guiding future judicial and medical decision-making. The judgment provides much-needed certainty for hospitals, physicians, patients, and families confronted with complex end-of-life decisions while reaffirming that constitutional protection under Article 21 encompasses not merely the preservation of biological existence but also respect for dignity, autonomy, and compassionate medical care.[46] At the same time, the decision highlights the continuing absence of comprehensive legislation governing end-of-life decision-making in India. Although judicial intervention has progressively clarified the constitutional dimensions of passive euthanasia, the absence of a detailed statutory framework continues to generate practical difficulties concerning institutional procedures, medical accountability, substitute decision-making, and uniform implementation across healthcare institutions. Consequently, *Harish Rana* should be regarded not as the culmination of India's right-to-die jurisprudence but as a significant constitutional milestone that reinforces the urgent need for legislative intervention capable of translating judicial principles into a comprehensive and accessible legal framework governing the right to die with dignity.

[46] *Shivani Mody, The Right to Die with Dignity: Indian Supreme Court in Harish Rana v. Union of India, Oxford Hum. Rts. Hub (Mar. 31, 2026), https://ohrh.law.ox.ac.uk/the-right-to-die-with-dignity-indian-supreme-court-in-harish-rana-v-union-of-india/ (last visited July 10, 2026) (on file with author).*

CHAPTER V – CONTEMPORARY CHALLENGES AND THE FUTURE OF END-OF-LIFE JURISPRUDENCE IN INDIA

The judicial recognition of the Right to Die with Dignity under Article 21 represents a significant constitutional achievement. Through decisions such as *Gian Kaur*, *Aruna Ramachandra Shanbaug*, *Common Cause*, and most recently *Harish Rana*, the Supreme Court has gradually transformed end-of-life decision-making from a purely criminal law issue into an integral aspect of constitutional liberty, dignity, and autonomy. Nevertheless, despite this progressive judicial evolution, substantial practical and legal challenges continue to hinder the effective implementation of these constitutional guarantees. The absence of comprehensive legislation, inconsistent medical practices, ethical dilemmas, and institutional uncertainty demonstrate that constitutional recognition alone cannot ensure the effective protection of end-of-life rights.

One of the most significant challenges is the continued absence of a comprehensive statutory framework governing passive euthanasia and Advance Medical Directives. At present, the legal position is largely regulated through judicial guidelines formulated by the Supreme Court. While these decisions possess binding authority under Article 141 of the Constitution, judicial guidelines cannot replace detailed legislation capable of regulating the numerous medical, administrative, and procedural issues that arise in clinical practice. Questions concerning the registration, modification, revocation, verification, and enforcement of Advance Medical Directives continue to depend primarily upon institutional interpretation, resulting in inconsistent implementation across healthcare institutions.

Another challenge concerns medical uncertainty and institutional accountability. Decisions regarding withdrawal of life-sustaining treatment require complex medical assessments involving prognosis, neurological evaluation, palliative care, and informed consent. Physicians are frequently required to balance competing ethical obligations of preserving life, respecting patient autonomy, and preventing avoidable suffering. In the absence of statutory immunity and uniform clinical protocols, many healthcare professionals remain reluctant to implement passive euthanasia due to concerns regarding potential criminal prosecution or professional misconduct proceedings. This uncertainty ultimately affects patients whose constitutional rights depend upon timely medical decision-making.

Equally significant are the ethical dilemmas surrounding end-of-life decision-making. The constitutional recognition of patient autonomy does not eliminate the ethical obligation to

protect vulnerable individuals from coercion, undue influence, or economic pressure. Elderly persons, patients suffering from severe disabilities, and individuals lacking adequate family support may become particularly vulnerable to decisions motivated by financial considerations rather than genuine respect for personal autonomy. Consequently, constitutional protection of dignity must always be balanced against the State's obligation to safeguard vulnerable persons from abuse. Bioethical scholarship consistently emphasises that autonomy and protection are complementary rather than competing constitutional values.

The implementation of Advance Medical Directives also faces substantial social and institutional barriers. Public awareness regarding living wills remains extremely limited, and many individuals remain unfamiliar with the legal recognition of end-of-life choices. Hospitals often lack specialised ethics committees, trained palliative care professionals, or institutional procedures for implementing judicial guidelines. Furthermore, cultural and religious attitudes surrounding death frequently discourage discussions concerning advance healthcare planning, thereby reducing the practical effectiveness of constitutional protections recognised by the Supreme Court.[47]

A comparative analysis demonstrates that several jurisdictions have adopted comprehensive statutory mechanisms to regulate end-of-life decisions. The Netherlands, through the Termination of Life on Request and Assisted Suicide (Review Procedures) Act, 2002, permits euthanasia under carefully regulated statutory conditions involving unbearable suffering, voluntary and informed consent, and mandatory review by independent committees. Similarly, Belgium's Euthanasia Act, 2002 establishes detailed procedural safeguards, mandatory reporting requirements, and independent oversight mechanisms.[48] Unlike India, these jurisdictions regulate end-of-life rights primarily through legislation rather than judicial guidelines, thereby ensuring greater legal certainty for patients and healthcare professionals alike.

Other jurisdictions have adopted a more cautious approach while still recognising patient autonomy. In the United Kingdom, active euthanasia continues to remain unlawful; however, courts recognise the legality of withdrawing life-sustaining treatment where continued intervention no longer serves the patient's best interests, as established in *Airedale NHS Trust*

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[47] Hendry et al., Why Do We Want the Right to Die? A Systematic Review of the International Literature on the Views of Patients, Carers and the Public on Assisted Dying, 27 Palliative Med. 13, 8 (2013).

[48] Termination of Life on Request and Assisted Suicide (Review Procedures) Act, Stb. 2001, 194 (Neth.); Loi relative à l'euthanasie [Act on Euthanasia] of May 28, 2002, Moniteur Belge [M.B.] June 22, 2002 (Belg.).

v. Bland. Likewise, many states within the United States recognise Advance Medical Directives through legislation, enabling competent adults to determine future medical treatment in situations involving incapacity. These comparative experiences demonstrate that legislative regulation, accompanied by robust procedural safeguards, offers greater clarity than reliance solely upon judicial pronouncements.

The Indian legal framework would benefit substantially from a dedicated parliamentary enactment governing passive euthanasia and Advance Medical Directives. Such legislation should clearly define terminal illness, permanent vegetative state, medical futility, informed consent, substituted decision-making, and the legal effect of Advance Medical Directives. It should also prescribe uniform procedures applicable throughout the country, establish hospital ethics committees, provide statutory protection to medical practitioners acting in good faith, and create mechanisms for periodic review and oversight. Uniform legislation would significantly reduce institutional uncertainty while preserving the constitutional values articulated by the Supreme Court.[49]

Equally important is the need to strengthen palliative care throughout India. The Right to Die with Dignity cannot be understood solely as a right relating to euthanasia. Constitutional dignity also requires effective pain management, psychological support, and access to quality end-of-life healthcare. The World Health Organization has consistently emphasised that palliative care constitutes an essential component of universal healthcare and should be available alongside any legal framework governing end-of-life decision-making. Strengthening palliative care infrastructure would ensure that requests for withdrawal of treatment arise from genuine autonomous choice rather than inadequate access to healthcare services.[50] The future of end-of-life jurisprudence in India ultimately lies in harmonising constitutional rights with legislative certainty, medical ethics, and institutional accountability. Judicial interpretation has successfully established the constitutional foundation by recognising dignity, autonomy, and self-determination as essential components of Article 21. The next stage of legal development must therefore focus upon translating these constitutional principles into an effective statutory framework capable of ensuring uniform implementation across healthcare institutions. Only then can the constitutional promise of the Right to Die with Dignity become a meaningful reality for every individual.

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[49] *Suresh B. Math & Santosh K. Chaturvedi, Euthanasia: Right to Life vs Right to Die, 136 Indian J. Med. Res. 899, 3 (2012).*
[50] *World Health Organization, Palliative Care (2020).*

CHAPTER VI – CONCLUSION

The evolution of the Right to Die with Dignity under Article 21 reflects one of the most profound developments in Indian constitutional jurisprudence. Through progressive judicial interpretation, the Supreme Court has transformed Article 21 from a guarantee of mere survival into a repository of substantive rights founded upon human dignity, personal liberty, bodily autonomy, privacy, and self-determination. The constitutional journey from *P. Rathinam v. Union of India* to *Gian Kaur v. State of Punjab*, *Aruna Ramachandra Shanbaug v. Union of India*, *Common Cause v. Union of India*, and ultimately *Harish Rana v. Union of India* demonstrates the judiciary's consistent endeavour to reconcile the sanctity of life with the dignity of the dying process.

This study establishes that the Right to Die with Dignity is no longer a matter of ethical or philosophical debate alone but has attained constitutional recognition as an integral component of Article 21. The recognition of passive euthanasia and Advance Medical Directives signifies a shift towards a rights-based approach that prioritises informed consent, patient autonomy, and dignity at the end of life. However, despite these significant judicial developments, the absence of a comprehensive statutory framework continues to create practical and procedural uncertainties, limiting the effective implementation of these constitutional guarantees.

While the judgment of *Harish Rana* significantly strengthened the practical application of the constitutional framework governing passive euthanasia, certain limitations remain. The Supreme Court continued to rely upon judicial guidelines rather than advocating a comprehensive legislative framework governing end-of-life decision-making. Consequently, important questions concerning the uniform implementation of Advance Medical Directives, the establishment of hospital ethics committees, statutory protection for medical practitioners acting in good faith, and standardised institutional procedures remain unresolved. Although *Harish Rana* provides greater clarity regarding the withdrawal of life-sustaining treatment, particularly Clinically Assisted Nutrition and Hydration, the absence of detailed legislation continues to create uncertainty across healthcare institutions. Thus, the judgment represents a substantial constitutional advancement but cannot, by itself, substitute for a comprehensive statutory regime capable of ensuring consistent, accessible, and effective protection of the Right to Die with Dignity.

Accordingly, this paper concludes that judicial innovation, though indispensable, cannot by itself provide a complete legal framework for regulating end-of-life decision-making.

Legislative intervention is now essential to codify uniform procedures, strengthen institutional safeguards, protect medical professionals acting in good faith, and ensure that constitutional rights are implemented consistently across the country. Ultimately, the true constitutional promise of Article 21 lies not merely in safeguarding the right to live but in ensuring that every individual is permitted to approach the natural end of life with dignity, autonomy, compassion, and respect.