Page: 206-240 *URL: www.lijdlr.com*

LAWFOYER INTERNATIONAL JOURNAL OF DOCTRINAL LEGAL RESEARCH

ISSN: 2583-7753

LawFoyer International Journal of Doctrinal Legal Research

[ISSN: 2583-7753]

Volume 4 | Issue 4

2026

DOI: https://doi.org/10.70183/lijdlr.2026.v04.385

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FROM LIVING WITH DIGNITY TO DYING WITH DIGNITY: THE CONSTITUTIONAL EVOLUTION OF ARTICLE 21 IN INDIA WITH SPECIAL EMPHASIS ON EUTHANASIA AND HARISH RANA CASE

Amit Maheshwari[1] & Neha Bhardwaj[2]

I. ABSTRACT

Over the years, euthanasia has generated considerable controversy. It is a long-standing problem with roots in classical thought and in humanist and compassionate philosophies. Article 21 of the Constitution guarantees the inalienable right to life, but the essence of human life lies in living with dignity rather than in mere biological existence. The idea of dying with dignity has brought about significant changes in this area. India does not yet have a specific statute on euthanasia; the Supreme Court has, however, recognised passive euthanasia, and until Parliament legislates on the subject, the guidelines laid down by the Court must be followed. Article 21 of the Constitution of India guarantees the right to life and personal liberty and protects every person's right to live with dignity and freedom, subject to procedure established by law. This article examines whether the right to die with dignity forms part of the right to live with dignity. Tracing the judicial path from State of Maharashtra v Maruti Shripati Dubal and P Rathinam through Gian Kaur, Aruna Shanbaug and Common Cause to the recent Harish Rana decision, it discusses passive euthanasia, end-of-life decisions, living wills and patient autonomy, and the extent to which Article 21 now encompasses a right to die with dignity in certain circumstances, subject to legal safeguards. The article shows how the Indian legal position has evolved gradually: the claim to a general right to die was rejected, but once the distinction between suicide and the natural process of dying was

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drawn, the right to die with dignity came to be recognised. Active euthanasia, however, remains prohibited in India, and a comprehensive legislative framework is therefore required.

II. KEYWORDS

Article 21, Right to die with dignity, Passive euthanasia, Advance medical directive, Active euthanasia.

III. INTRODUCTION

"Life sans dignity is an unacceptable defeat and life that meets death with dignity is a value to be aspired for and a moment for celebration"- Dipak Misra, Former C.J.I.[3]

Taking one's own life in an unnatural manner runs against the norm. When a person causes the death of another at the latter's request in order to relieve suffering, the act is called 'euthanasia' or 'mercy killing'; when a person takes his or her own life, it is called 'suicide'. Euthanasia is mostly associated with terminally ill persons, or with persons with severe disabilities who wish to escape prolonged pain. Its supporters argue that a person who is seriously disabled or terminally ill should be able to choose whether to continue living. Indian law, however, does not recognise a general right to die, as the Constitution Bench held in *Gian Kaur v State of Punjab*.[4]

Euthanasia is a controversial issue that engages the ethics, principles and beliefs of society, and it has been debated throughout the world. The discourse has gained renewed importance in India after the Supreme Court's decision in *Harish Rana v Union of India*,[5] which permitted the first judicially sanctioned withdrawal of life-sustaining treatment under the *Common Cause* framework. Yet India still has no statute governing end-of-life decisions, and the field is regulated entirely by judge-made guidelines. This absence of a legislative framework, despite nearly two decades of judicial development, is the research problem that this article addresses.

[3] *Common Cause (A Regd Society) v Union of India* (2018) 5 SCC 1 (Dipak Misra CJ).
[4] *Gian Kaur v State of Punjab* (1996) 2 SCC 648.
[5] *Harish Rana v Union of India* 2026 INSC 222, 2026 SCC OnLine SC 358.

Euthanasia is often confused with, or used synonymously with, 'suicide', but the two are distinct acts and must be differentiated. The Oxford Dictionary defines suicide as *"the act of killing yourself deliberately."*[6] It is the intentional taking of one's own life by one's own hand, for reasons such as romantic disappointment, academic failure or unemployment, but most often depression. The Bombay High Court in *State of Maharashtra v Maruti Shripati Dubal*[7] drew a line between suicide and euthanasia or mercy killing. According to the Court, *"the suicide by its very nature is an act of self-killing or termination of one's own life by one's act without assistance from others. But euthanasia means the intervention of other human agency to end the life."*

Euthanasia is therefore not the same as suicide. In *Naresh Marotrao Sakhre v Union of India*,[8] the Bombay High Court likewise observed that *"suicide by its very nature is an act of self-killing or self-destruction, an act of terminating one's own act and without the aid and assistance of any other human agency"*, and regarded euthanasia or mercy killing as nothing but homicide, whatever the circumstances. That observation, made in 1994, predates the Supreme Court's later decisions. The present law distinguishes between the two forms of euthanasia: active euthanasia, involving a positive act to cause death, remains unlawful, whereas passive euthanasia, that is, the withdrawal or withholding of life-sustaining treatment, is lawful under the framework laid down in *Aruna Shanbaug*, *Common Cause* (2018 and 2023) and *Harish Rana*.[9] Suicide and euthanasia thus remain factually and legally distinct notions.

A. Research Objectives

The objectives of this study are:

[6] *Oxford Learner's Dictionaries*, 'Suicide' <https://www.oxfordlearnersdictionaries.com/definition/english/suicide>.
[7] *State of Maharashtra v Maruti Shripati Dubal* 1987 Cri LJ 743 (Bom).
[8] *Naresh Marotrao Sakhre v Union of India* 1995 Cri LJ 96 (Bom).
[9] *Aruna Ramchandra Shanbaug v Union of India* (2011) 4 SCC 454; *Common Cause* (2018) (n 1); *Common Cause (A Regd Society) v Union of India* (2023) 14 SCC 131; *Harish Rana* (n 3).

1. To trace how Article 21 has evolved from the right to live with dignity to the recognition of a right to die with dignity;
2. To examine the statutory and regulatory provisions that bear on end-of-life decisions in India;
3. To analyse the leading judicial decisions from *Maruti Shripati Dubal* to *Harish Rana*; and
4. To propose legal and policy measures for a comprehensive statutory framework.

B. Research Questions

The study addresses the following questions:

1. Does the right to life under Article 21 include a right to die with dignity and, if so, within what limits?
2. How far do the Bharatiya Nyaya Sanhita, 2023, the Mental Healthcare Act, 2017 and the medical ethics regulations accommodate the withdrawal of life-sustaining treatment?
3. What did *Harish Rana* add to the *Common Cause* framework?
4. Is the judge-made framework adequate, or is legislation required?

C. Research Methodology

The study is doctrinal. It relies on primary sources, namely the Constitution of India, the Bharatiya Nyaya Sanhita, 2023, the Indian Penal Code, 1860, the Mental Healthcare Act, 2017, the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, Law Commission reports, government guidelines and orders, and judgments of the Supreme Court and High Courts; and on secondary sources, namely books, journal articles and reliable web sources. Citations follow the Oxford University Standard for the Citation of Legal Authorities (OSCOLA), 4th edition.

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IV. HISTORICAL EVOLUTION AND RELIGIOUS PERSPECTIVES ON EUTHANASIA

In human society, the idea of a right to die or to end one's life is not new. In ancient Greece and Rome, assisting another person to die, or putting another person to death, was acceptable in rare circumstances; in Sparta, for instance, infants with serious birth defects were put to death. Voluntary euthanasia of the elderly was accepted in many ancient communities. Suicide and self-destruction are mentioned in a number of ancient texts, including the Bible, the Quran and the Rig Veda, and there are numerous instances of religiously motivated suicide in India's Vedic era.[10]

There are numerous examples of religious suicide in the Mahabharata and the Ramayana. Since euthanasia may separate the soul from the body at an unnatural moment, most Hindus believe that a doctor should not accede to a patient's request for it, as the karma of both the patient and the doctor may suffer. Other Hindus regard euthanasia as prohibited because it violates the principle of ahimsa.[11] Hindus therefore hold two views on euthanasia. On the first, a person who helps to end a painful existence performs a good deed and fulfils a moral obligation. On the second, helping to end a life, even one full of suffering, disrupts the timing of the cycle of death and rebirth; this is wrong, and those who carry out the euthanasia take on the patient's remaining karma. By the same reasoning, it would be unethical to keep a person alive artificially on a life-support system.[12]

On the other hand, using life-support equipment as part of a short-term effort at healing would not be harmful. Palliative care may be problematic if it lowers mental alertness, because the ideal death is a conscious one. Religious arguments against euthanasia

[10] Asha Sebastian, 'Legality of Passive Euthanasia in India' (2023) 5 Indian Journal of Law and Legal Research 1.
[11] Shruti Pandey, 'Position of Euthanasia in India: Legal Perspective' (2022) 2 Indian Journal of Integrated Research in Law.
[12] Purushottama Bilimoria, 'The Bioethics of Euthanasia in India: Past and Present' (*Sightings*, University of Chicago Divinity School, 18 December 2014) <https://divinity.uchicago.edu/sightings/articles/bioethics-euthanasia-india-past-and-present>.

typically rest on the claims that life is a gift from God and that human beings are created in God's image. Birth and death are part of the life processes that God designed and should be respected; therefore, no human being has the right to kill an innocent person, even one who wishes to die. The belief that life is a gift from God is shared by most religions.[13] Every faith explains death and dying in its own way, and the two ideas cannot be separated. The views of the major religions are as follows: -

1. **Hinduism view:** Hinduism holds varying perspectives on euthanasia. In *Common Cause*, Justice Ashok Bhushan noted the connection between religion and euthanasia, observing that "*In ancient Indian religion, sanctity was associated with a yogi who could discard his body through the process of higher spiritual practices called yoga*"; such a state was called "*Samadhi*".[14] Conversely, Hindu texts such as the Manusmriti and the Yajnavalkya Smriti condemn self-destruction, including fasting unto death, and those who die by suicide are believed not to attain moksha, or release from the cycle of life and death.[15]
2. **Islamic view:** Euthanasia is prohibited in Islam. Muslims believe that life is a sacred gift from Allah, who alone determines a person's lifespan, and that no one may take this gift away. On this view, euthanasia is *haram*, and a physician may not actively end a patient's life even where there is no chance of recovery.[16]
3. **Christianity view:** Christianity also opposes euthanasia. According to the Bible, the human body is the temple of the Holy Spirit. Since Jesus healed the sick but did not kill, Christians are called to care for the sick rather than to end their lives. Some Christians nevertheless support euthanasia on the basis of

[13] Mousumi Kalita, 'Euthanasia: A Comprehensive Analysis on Indian Perspective' (2024) 10 Law and World 20.
[14] *Common Cause* (2018) (n 1) (Ashok Bhushan J).
[15] S Tharani, 'A Socio Legal Study on Euthanasia in India: A Dignified End of Life' (2021) 4 International Journal of Law Management and Humanities 2621.
[16] M Narimisa, 'Euthanasia in Islamic Views' (2014) 2 European Scientific Journal 170.

love, which is central to Christianity, arguing that it may be the most compassionate way to end a person's suffering.[17]

4. **Jainism view:** The idea and practice of a voluntary religious death are not new to Jainism. Jain doctrine recognises "*Sallekhana*" or "*Samadhi-marana*", a religiously sanctioned fast unto death, which may be undertaken by both householders and ascetics and is still practised in India.[18]
5. **Buddhism view:** Buddhists hold a variety of views on euthanasia. Some regard it as justified by compassion, and certain scriptural accounts describe the Buddha as showing compassion towards gravely ill monks who chose to end their own lives.[19]

V. MEANING OF EUTHANASIA, END OF LIFE DECISIONS, ADVANCE MEDICAL DIRECTIVE AND LIVING WILLS AND PATIENT AUTONOMY AND TYPES OF EUTHANASIA

A. Meaning and Types of Euthanasia

Sir Francis Bacon, an English philosopher, introduced the term "euthanasia" in the 17th century to denote an 'easy', 'painless', and 'happy death'.[20] The term "Euthanasia" originates from Greek, consisting of "Eu" signifying good, and "Thanatos", meaning death; collectively, it translates to "Good Death" or "Easy Death".[21] The concept encapsulated by the term suggests that every individual is entitled to a dignified death; if someone is enduring significant suffering and is unable to act, it cannot be considered a good death.

[17] *Catechism of the Catholic Church* (2nd edn, Libreria Editrice Vaticana 1997) paras 2276–2279; 1 Corinthians 6:19–20; for the contrary view, see Hans Küng and Walter Jens, *A Dignified Dying: A Plea for Personal Responsibility* (SCM Press 1995).
[18] Whitny Braun, 'Sallekhana: The Ethicality and Legality of Religious Suicide by Starvation in the Jain Religious Community' (2008) 27 Medicine and Law 913.
[19] Damien Keown, 'Suicide, Assisted Suicide and Euthanasia: A Buddhist Perspective' (1998) 13 Journal of Law and Religion 385.
[20] Pandey (n 9).
[21] ibid.

The Oxford dictionary defines euthanasia as "*the painless killing of a patient suffering from an incurable and painful disease or in an irreversible coma.*"[22] As defined by the Merriam-Webster Dictionary, euthanasia refers to "*the act or practice of killing or permitting the death of hopelessly sick or injured individuals in a relatively painless way for reasons of mercy.*"[23] Furthermore, Black's Law Dictionary defines euthanasia as "*an act or practice of killing or bringing about the death of a person who suffers from an incurable disease or condition especially a painful one, for reasons of mercy.*"[24] Euthanasia exists in multiple forms, including: -

1. **Active Euthanasia:** Active euthanasia is the intentional causing of a patient's death through a positive act, for example where a physician administers a lethal dose of medication to a terminally ill patient. Such a patient, being unable to bring about his or her own death, needs another person's help to do so. Active euthanasia is unlawful in India and is punishable as murder under Section 101 of the Bharatiya Nyaya Sanhita, 2023 (BNS) (Section 300 of the Indian Penal Code, 1860 (IPC)), or as culpable homicide, while physician-assisted suicide is punishable as abetment of suicide under Section 108 BNS (Section 306 IPC).[25]
2. **Passive Euthanasia:** Passive euthanasia involves withholding or withdrawing treatment that is essential to sustain life, such as antibiotics or life-support equipment. It entails refraining from steps that would prevent death, as when a physician withdraws, or does not use, the equipment needed to keep alive a patient in a persistent vegetative state (PVS) or a terminally ill patient. Passive euthanasia is generally regarded as less cruel than active euthanasia, and it is the only form of euthanasia that is lawful in India, subject

[22] *Oxford Reference*, 'Euthanasia' (OUP 2005) <https://www.oxfordreference.com/display/10.1093/acref/9780198609810.001.0001/acref-9780198609810-e-2515>.
[23] *Merriam-Webster Dictionary*, 'Euthanasia' <https://www.merriam-webster.com/dictionary/euthanasia>.
[24] Henry Campbell Black, *Black's Law Dictionary* (4th edn, West Publishing 1971) 730.
[25] Bharatiya Nyaya Sanhita 2023, ss 101 and 108; Indian Penal Code 1860, ss 300 and 306; see also Sailaja Petikam, 'Euthanasia in India – Legislative Perspective' (2021) 4 Rev Dr Const 43.

to the safeguards laid down by the Supreme Court. In passive euthanasia, doctors do not actively kill the patient; they refrain from prolonging life through futile treatment.[26]

The consent of the patient is central to understanding euthanasia. On the basis of consent, there are mainly three types of euthanasia: -

1. **Voluntary Euthanasia:** In voluntary euthanasia, a person requests death by either active or passive means. In essence, it concerns a terminally ill patient's freedom to choose whether to end his or her life in the manner best for the patient and everyone involved. It is carried out with the patient's express wish and consent.[27]
2. **Involuntary Euthanasia:** Involuntary euthanasia occurs when a patient is killed against his or her will, and it is unlawful as murder. It thus takes place where the recipient is unwilling and has not consented. Euthanasia may be described as involuntary where a person who is capable of giving consent does not do so, either because he or she is not asked or because he or she is asked and chooses to live. Admittedly, this description combines two distinct situations under one heading.[28] Killing a person who has not consented but would have consented if asked is very different from killing a person who wishes to live. In practice, however, it is difficult to envisage a case in which a person capable of consenting would have done so if asked, but was not asked.[29]
3. **Non-voluntary Euthanasia:** Non-voluntary euthanasia is the ending of the life of a person who lacks the mental capacity to make an informed decision about his or her own death, such as a patient in a coma. It covers situations in which the patient has not expressed a wish to die in a will or other document, and

[26] *Aruna Shanbaug* (n 7); *Common Cause* (2018) (n 1).
[27] Pandey (n 9).
[28] Vibhu Aggarwal, 'Euthanasia in India – An Analytical Study' (2020) 19 Supremo Amicus 635.
[29] ibid.

family members are left to decide. Euthanasia is non-voluntary where the individual is incapable of understanding the choice between life and death.[30]

B. End of Life Decisions

End-of-life decisions are decisions made when a patient is in the last stage of life or has no realistic possibility of recovery. They mainly comprise four elements.[31]

First, withholding treatment, that is, not starting a treatment.

Second, withdrawing treatment, such as discontinuing a ventilator.

Third, palliative care or sedation, the aim of which is to relieve pain and suffering; according to the WHO, palliative care improves the quality of life of patients and their families by addressing pain and physical, psychosocial and spiritual problems.

Fourth, a do-not-resuscitate (DNR) order, which is a medical instruction that CPR is not to be performed when the patient suffers cardiac arrest or stops breathing.[32] The purpose of these decisions is to avoid futile treatment, not to cause death, which distinguishes them from euthanasia.

C. Advance Medical Directive and Living Wills

An advance medical directive is a document executed by a competent adult of sound mind for situations in which he or she may later lose the capacity to think or decide, so that his or her wishes are followed when he or she is unable to express them. A living will be the common form of advance medical directive: in it, a person states whether life-prolonging treatment, such as ventilation or resuscitation, should be refused if he or she develops a terminal illness or irreversible unconsciousness.

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[30] Aggarwal (n 26).
[31] Raj K Mani and others, 'Indian Society of Critical Care Medicine and Indian Association of Palliative Care Expert Consensus and Position Statements for End-of-Life and Palliative Care in the Intensive Care Unit' (2024) 28 Indian Journal of Critical Care Medicine 200.
[32] Sheila Nainan Myatra and others, 'End-of-Life Care Policy: An Integrated Care Plan for the Dying' (2014) 18 Indian Journal of Critical Care Medicine 615.

An advance directive is the broader concept, because it may also appoint a guardian or close relative to take decisions on the patient's behalf, whereas a living will contain only treatment instructions. Both aim to protect the patient's autonomy when he or she cannot communicate. India has no statute on these instruments, but the Supreme Court in *Common Cause v Union of India (2018)*[33] laid down guidelines for their execution, which were simplified in *2023*.[34] The document must be executed voluntarily and in clear terms, signed in the presence of two attesting witnesses and attested before a notary or gazetted officer, and it may be revoked by the executor at any time. It permits only passive euthanasia, never active euthanasia.

D. Patient Autonomy

The principle of autonomy states that "*A competent adult has the right to decide what happens to their own body.*"[35] An adult therefore has the right to choose whether or not to accept treatment. The doctor's duty is to explain the diagnosis, the risks and the available alternatives, and treating a patient without consent violates his or her bodily integrity. The right to choose treatment includes the right to refuse it, even if the refusal may result in death.

The legal foundation of autonomy is traced to *Schloendorff v Society of New York Hospital (1914)*,[36] where it was held that treating a patient without consent is a wrong. In India, in *Samira Kohli v Dr Prabha Manchanda (2008)*,[37] the Supreme Court emphasised the importance of informed consent. Autonomy depends on capacity: the person must be capable of making the decision. Autonomy is not absolute; when a person loses the capacity to choose, advance medical directives or living wills are used to give effect to his or her wishes.

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[33] *Common Cause* (2018) (n 1).
[34] *Common Cause* (2023) (n 7).
[35] Subhash Chandra Singh, 'Non-Consensual Medical Treatment: The Legal Justification' (2013) IUP Law Review.
[36] *Schloendorff v Society of New York Hospital* 211 NY 125, 105 NE 92 (NY 1914).
[37] *Samira Kohli v Dr Prabha Manchanda* (2008) 2 SCC 1.

VI. LEGISLATIVE FRAMEWORK, JUDICIAL AND CONSTITUTIONAL EVOLUTION REGARDING RIGHT TO DIE WITH DIGNITY IN INDIA

Although there is no specific law governing euthanasia in India, active euthanasia is punishable under the BNS, 2023, and end-of-life decisions are also addressed by the Constitution, the medical ethics regulations and the judgments of the Supreme Court.

A. The Indian Constitution

Article 21 of the Constitution[38] provides that no person shall be deprived of life or personal liberty except according to procedure established by law.[39] Its scope has expanded steadily. In *Maneka Gandhi v Union of India*,[40] the Supreme Court held that the procedure depriving a person of life or liberty must be just, fair and reasonable, transforming Article 21 from a purely procedural safeguard into a substantive guarantee. In *Francis Coralie Mullin v Administrator, Union Territory of Delhi*,[41] the Court held that the right to life includes the right to live with human dignity and all that goes with it. In *K S Puttaswamy v Union of India*,[42] a nine-judge Bench recognised privacy, bodily autonomy and decisional freedom as intrinsic to life and liberty under Article 21.

These decisions supply the foundation for the end-of-life jurisprudence. *Gian Kaur* held that Article 21 does not include a right to die, but accepted that the right to live with dignity extends to the dignity of a dying person;[43] *Common Cause* (2018) drew on dignity and autonomy to recognise the right to die with dignity through advance directives and the withdrawal of futile treatment;[44] and *Harish Rana* applied that framework to a patient who had left no advance directive.[45] Article 21 is therefore at the centre of the euthanasia

[38] Constitution of India 1950.
[39] Constitution of India 1950, art 21.
[40] *Maneka Gandhi v Union of India* (1978) 1 SCC 248.
[41] *Francis Coralie Mullin v Administrator, Union Territory of Delhi* (1981) 1 SCC 608.
[42] *K S Puttaswamy v Union of India* (2017) 10 SCC 1.
[43] *Gian Kaur* (n 2).
[44] *Common Cause* (2018) (n 1).
[45] *Harish Rana* (n 3).

debate, and its evolution from living with dignity to dying with dignity is the thread that runs through this article.

B. The Bharatiya Nyaya Sanhita, 2023

The Bharatiya Nyaya Sanhita, 2023 (BNS)[46], which replaced the IPC, does not create a right to die. Section 108 BNS penalises abetment of suicide and corresponds to Section 306 IPC.[47] Significantly, the BNS omits the general offence of attempting suicide formerly contained in Section 309 IPC. The only residual provision is Section 226 BNS, which punishes an attempt to commit suicide made with intent to compel or restrain a public servant in the discharge of official duty.[48]

Even before the BNS, Section 115 of the Mental Healthcare Act, 2017 provided that a person who attempts suicide shall be presumed, unless proved otherwise, to have severe stress and shall not be tried and punished under Section 309 IPC.[49] The decriminalisation of attempted suicide reflects a therapeutic rather than punitive approach; it does not, however, create an enforceable right to die, and the law continues to punish any person who assists another to die.

It may be argued that withdrawing a patient's life support could constitute murder under *Section 101*[50] or culpable homicide under *Section 100*[51] of the BNS. The relevant test is not motive but intention or knowledge: the question is whether the doctor acts with the intention of causing death, or with knowledge that the act is likely to cause death. *Exception 5 to Section 101*[52] does not render a consensual killing lawful; it only reduces murder to culpable homicide not amounting to murder, punishable under Section 105 BNS. The general exceptions for acts done in good faith for a person's benefit with consent

[46] Bharatiya Nyaya Sanhita 2023 (Act 45 of 2023).
[47] Bharatiya Nyaya Sanhita 2023, s 108; Indian Penal Code 1860, s 306.
[48] Bharatiya Nyaya Sanhita 2023, s 226.
[49] Mental Healthcare Act 2017, s 115.
[50] Bharatiya Nyaya Sanhita 2023, s 101; Indian Penal Code 1860, s 300.
[51] Bharatiya Nyaya Sanhita 2023, s 100; Indian Penal Code 1860, s 299.
[52] Bharatiya Nyaya Sanhita 2023, s 101, Exception 5 and s 105; Indian Penal Code 1860, s 300, Exception 5 and s 304.

(Section 26 BNS, corresponding to Section 88 IPC) or without consent (Section 30 BNS, corresponding to Section 92 IPC) do not extend to the intentional causing of death.[53]

The concern about criminal liability is instead resolved by the Supreme Court's treatment of the withdrawal of futile treatment, in *Common Cause* and *Harish Rana*, as a lawful omission consistent with the doctor's duty of care rather than an act causing death.[54] Strict adherence to the prescribed safeguards also guards against the risk that consent may be vitiated by undue influence or improper motives.

C. The Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002

The *Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002* govern the professional conduct of registered medical practitioners. *Regulation 6.7*[55] provides that "*Practicing euthanasia shall constitute unethical conduct.*" It adds that, on specific occasions, the question of withdrawing supporting devices to sustain cardio-pulmonary function even after brain death "*shall be decided only by a team of doctors and not merely by the treating physician alone*", the team comprising the doctor in charge of the patient, the Chief Medical Officer or Medical Officer in charge of the hospital, and a doctor nominated by the in-charge of the hospital.

The Regulation thus prohibits euthanasia and permits team-based withdrawal of support only after brain death; it does not address patients in a persistent vegetative state, for whom the legal framework is supplied separately by ***Common Cause***. The National Medical Commission's Registered Medical Practitioner (Professional Conduct) Regulations, 2023 were placed in abeyance on 23 August 2023, so the 2002 Regulations continue to apply.[56]

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[53] Bharatiya Nyaya Sanhita 2023, ss 26 and 30; Indian Penal Code 1860, ss 88 and 92.
[54] *Common Cause* (2018) (n 1); *Harish Rana* (n 3).
[55] Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations 2002, reg 6.7.
[56] National Medical Commission, Registered Medical Practitioner (Professional Conduct) Regulations 2023, held in abeyance by notification dated 23 August 2023.

D. Judicial Precedents

1. State of Maharashtra v Maruti Shripati Dubal (1986)

Maruti Shripati Dubal, a police constable with 19 years of service, developed a mental illness after a road accident in 1981. He attempted suicide outside the office of the Municipal Commissioner of Greater Bombay by pouring kerosene on himself and trying to set his clothes alight. He was arrested under Section 309 IPC (attempt to commit suicide) and released on bail.[57]

The issues before the Court were whether Section 309 IPC violates Articles 14 and 21 of the Constitution, and whether the right to life with dignity under Article 21 includes the right to die. In 1986, the Bombay High Court held that Section 309 IPC violated Articles 14 and 21 and was unconstitutional, taking the view that the right to life under Article 21 includes the right to die. The judgment treated the punishment of attempted suicide as an infringement of a person's right to live with dignity and of personal autonomy.

This interpretation was rejected by the Supreme Court in Gian Kaur v State of Punjab (1996),[58] which held that the right to life under Article 21 does not include the right to die.

2. P Rathinam v Union of India (1994)

In this case, the Supreme Court examined the constitutional validity of Section 309 IPC. The matter arose from writ petitions filed by P Rathinam[59] and Nagbhusan Patnaik challenging the provision as violative of Articles 14 and 21 of the Constitution. Rathinam approached the Supreme Court under Article 32, which guarantees the right to move the Court for the enforcement of fundamental rights, and argued that punishing a person for attempting suicide was unjust and violated Article 21. Patnaik challenged the criminal proceedings pending against him under Section 309 IPC before the court at Gunupur, in the Koraput district of Odisha.

[57] *Maruti Shripati Dubal* (n 5).
[58] *Gian Kaur* (n 2).
[59] *P Rathinam v Union of India* (1994) 3 SCC 394.

The issues were whether treating attempted suicide as a criminal offence violates fundamental rights, in particular Articles 14, 19 and 21 of the Constitution, and whether the right to die with dignity is a facet of the right to life with dignity.

A two-judge Bench of the Supreme Court declared Section 309 IPC unconstitutional as violative of Article 21. The Court reasoned that a person who attempts suicide is already in mental distress, that punishing such a person is cruel, and that he or she should instead receive proper treatment through a humanitarian approach. The Court also held that the right to life under Article 21 includes the right to die.

3. Gian Kaur v State of Punjab (1996)

Gian Kaur and her husband Harbans Singh were convicted of abetting the suicide of their daughter-in-law, Kulwant Kaur. The trial court convicted them under Section 306 IPC and sentenced each of them to six years' rigorous imprisonment and a fine of Rs 2,000. The High Court maintained the sentence of Harbans Singh but reduced that of Gian Kaur to three years' rigorous imprisonment. On appeal to the Supreme Court, the appellants relied on *P Rathinam*, which had declared Section 309 IPC unconstitutional, and contended that Section 306 IPC was also unconstitutional: if suicide is a right, abetting the exercise of that right cannot be an offence. The State argued that Sections 306 and 309 IPC are distinct offences and that Section 306 would remain valid even if Section 309 fell.[60]

The main issues were whether Article 21 includes a right to die, whether Sections 306 and 309 IPC are constitutionally valid, and whether the appellants could still be convicted under Section 306 IPC.

The Constitution Bench, whose decision carries greater authority than that of the two-judge Bench in *P Rathinam*, held that Article 21 does not include a right to die, overruled *P Rathinam*, and upheld the constitutional validity of Sections 306 and 309 IPC. It held that Section 306 is a distinct offence which can survive independently of Section 309. The Court recognised that the right to live with dignity includes the dignity of a dying person,

[60] *Gian Kaur* (n 2).

which may be relevant where a terminally ill patient is in the process of natural death, but it distinguished this from the unnatural termination of life.

The Court did not decide the legality of euthanasia: it regarded the debate on euthanasia as irrelevant to the validity of Section 309 and left open the question of physician-assisted termination of life. The prohibition of active euthanasia was later laid down in *Aruna Shanbaug* and *Common Cause*. The convictions of Gian Kaur and Harbans Singh were upheld.

4. Aruna Ramchandra Shanbaug v Union of India (2011)

Aruna Shanbaug was a nurse at the King Edward Memorial (KEM) Hospital, Mumbai. On 27 November 1973, when she was 25 years old, she was assaulted by a ward boy and thereafter remained in a persistent vegetative state (PVS). The journalist and activist Ms Pinki Virani petitioned the Supreme Court under Article 32 as Aruna's 'next friend', seeking the withdrawal of life support so that Aruna could die with dignity. KEM Hospital and the Bombay Municipal Corporation opposed the petition.

The hospital staff, who by the date of the judgment (7 March 2011) had cared for Aruna for about 37 years, wished to keep her alive. The Attorney General, on behalf of the Union of India, argued that Aruna had a right to life and that withdrawing life support would be cruel and inhumane. Aruna Shanbaug later died on 18 May 2015, after about 42 years in that condition.[61]

The issues were whether Pinki Virani could petition as Aruna's 'next friend', whether the Court should permit the withdrawal of life support, and whether passive euthanasia is legal in India and, if so, under what procedure.

The Supreme Court held that the KEM Hospital staff, and not Pinki Virani, were entitled to act as Aruna's 'next friend', and therefore rejected the plea. On the basis of the report of a team of doctors, which found that Aruna was not brain dead, and the wishes of the

[61] *Aruna Shanbaug* (n 7).

hospital staff, the Court refused permission to withdraw life support. It distinguished active euthanasia, which is illegal and punishable in India, from passive euthanasia, which it held permissible with the approval of the High Court, thereby recognising passive euthanasia in India.

- **Guidelines given by the Court:** Where an application for passive euthanasia is filed, the Chief Justice of the High Court should constitute a Bench of at least two judges, which should obtain the opinion of a committee of three reputed doctors. The High Court should issue notice to the State and the close relatives, decide the matter speedily and act in the best interests of the patient, giving due weight to the views of the near relatives and the committee of doctors. The Court held that the High Court should exercise this power under Article 226.

5. Common Cause (A Regd Society) v Union of India (2018)

In 2005, Common Cause, a registered society, filed a writ petition under Article 32 seeking legal recognition of passive euthanasia and living wills. The petitioner argued that subjecting a person suffering from a terminal or chronic illness to prolonged treatment was cruel and inhumane; alternatively, it sought the constitution of an expert committee on living wills. During the hearing in October 2017, the Union opposed living wills because of the possibility of misuse, accepting only that a living will could be one of the factors considered by a medical board. The matter was first heard by a three-judge Bench and was later referred to a Constitution Bench because of an inconsistency between the views expressed in *Aruna Shanbaug* and *Gian Kaur*.[62]

The issues were whether a patient could be permitted passive euthanasia on the basis of a living will, what distinguishes active from passive euthanasia, whether Article 21 includes a right to die with dignity, and what guidelines should govern living wills.

[62] *Common Cause* (2018) (n 1).

The Court held that the right to die with dignity is part of Article 21, as distinct from any right to die by suicide, and differentiated between active and passive euthanasia: active euthanasia involves an overt act to end life and is not permitted in India, whereas passive euthanasia means withholding or withdrawing life-sustaining treatment. The Bench held that both the execution of living wills and passive euthanasia are lawful, subject to safeguards, and that life support may be withdrawn only where the medical boards certify that the patient's condition is incurable. The Court thereby recognised, under Article 21, the patient's right to make decisions about his or her own body and treatment.

- **Guidelines given by the court**
  - **Living will /Advance medical directive:** A competent adult may record his or her wishes about future medical treatment for a time when he or she is unable to take decisions. This document is called a living will or advance medical directive. In it, the person states whether, in the event of terminal illness or incurable disease, he or she wishes to receive artificial life support.
  - **Conditions for making living wills:** The person must be an adult of sound mind when executing the living will, which must be made voluntarily and without coercion or undue influence. It must state clearly whether treatment is to be withheld or withdrawn, and it should name a guardian or close relative to take medical decisions when the patient is unable to do so.
  - **Living will Authentication:** The judgment laid down the following safeguards for executing living wills:
    - The document had to be signed in the presence of two independent attesting witnesses.
    - The document had to be countersigned by the jurisdictional Judicial Magistrate of First Class (JMFC).
    - Copies of the document had to be preserved with the family members and the relevant authorities.

- **Role of Medical Board:** Where a patient is terminally ill and the question of withdrawing life support arises, a Medical Board must examine the patient's condition and assess whether continuing treatment offers any reasonable prospect of meaningful medical benefit. The decision is taken in accordance with the Medical Board's opinion and the prescribed procedure.
- **When no living will have been made:** If the patient has not executed a living will and is incapable of deciding because of a condition such as coma or a vegetative state, the views of close relatives, the next friend or a guardian are considered, and the decision is taken through the medical boards subject to the legal safeguards.
- **Role of the High Court:** The Supreme Court laid down the safeguards and the procedure to be followed. If the medical boards decline permission, or if any dispute arises about the prescribed procedure, the matter may be taken to the High Court.

6. Common Cause (A Regd Society) v Union of India (2023)[63]

After the 2018 judgment, living wills and passive euthanasia were legally recognised, but the procedure proved complicated. On 19 July 2019, the Indian Society of Critical Care Medicine filed a miscellaneous application in the Supreme Court stating that the 2018 guidelines were impractical, complicated and cumbersome for medical professionals, and a five-judge Constitution Bench heard the application.

The Society pointed out that the requirement of countersignature by the Judicial Magistrate of First Class (JMFC) and the medical board procedure created significant obstacles for patients, families and doctors, and could delay giving effect to a patient's wishes about end-of-life treatment. It therefore asked the Court to simplify the procedure.

[63] *Common Cause* (2023) (n 7).

On 24 January 2023, the Supreme Court modified the 2018 guidelines, acknowledging the practical difficulties in implementing them.

- **Modifications to 2018 Judgment**
  - **Living Will Authentication:** Under the 2018 judgment, a living will required countersignature by the JMFC. Under the 2023 modification, it must instead be attested before a notary or gazetted officer, which makes authentication easier.
  - **Preservation of copy of living will:** The Court modified the procedure for keeping copies of the living will. A copy may be provided to a guardian, close relative, family member or family physician, or to the relevant local government or municipal authority, so that the document is readily available when needed.
  - **Procedure of Medical Board:** The Court simplified the procedure of the Primary and Secondary Medical Boards, which examine the patient and assess whether continuing life-sustaining treatment is medically appropriate, and prescribed time limits for their decisions. Medical assessment and the prescribed safeguards must still be followed.
  - **Simplifying the involvement of JMFC:** Under the 2018 judgment, the JMFC was involved at several stages, including the implementation and verification of the living will. The 2023 modification removed the mandatory involvement of the JMFC at certain stages, including the requirement to visit the patient, in order to reduce delays and procedural formalities.
  - **To maintain Medical Safeguards:** The Court simplified the procedure without diluting patient safety or medical assessment. Decisions on life-sustaining treatment remain subject to the prescribed medical procedure and applicable safeguards; the Court's purpose was to respect patients' wishes and to reduce complications in end-of-life decisions.

- **Importance**

The 2018 judgment recognised the right to die with dignity, but its procedural requirements were difficult to implement. In 2023, the Supreme Court simplified the authentication and medical board procedures so that patients' difficulties are reduced and their wishes are honoured without delay.

7. Harish Rana v Union of India (2026)

Harish Rana[64] was a B.Tech student at Panjab University, Chandigarh. On 20 August 2013, at the age of 20, he fell from the fourth floor of his paying-guest accommodation and suffered a severe traumatic brain injury, resulting in diffuse axonal injury, quadriplegia and a prolonged vegetative state. As recorded in the judgment, he was treated at a local hospital in Garhwal, at the Postgraduate Institute of Medical Education and Research, Chandigarh, at the Jai Prakash Narayan Trauma Centre of AIIMS, New Delhi, and later at the District Hospital, Ghaziabad.[65]

He was kept alive through a tracheostomy and clinically assisted nutrition and hydration (CANH) administered through a PEG tube, and was wholly dependent on medical intervention, with 100% permanent disability and no realistic prospect of neurological recovery. By an order dated 2 July 2024, the Delhi High Court dismissed his parents' petition for the withdrawal of life-sustaining treatment, reasoning that he was not being kept alive by mechanical support.

On 8 November 2024, the Supreme Court disposed of the appeal with directions for home-based care at the State's expense, granting liberty to approach the Court again. On the family's subsequent application under the framework laid down in *Common Cause (2018)*,[66] the Court directed examination by Primary and Secondary Medical Boards. Both Boards found that he was in an irreversible persistent vegetative state

[64] *Harish Rana* (n 3).
[65] *Harish Rana* (n 3) [6]–[16].
[66] *Common Cause* (2018) (n 1).

with negligible chances of recovery, and that CANH, though necessary for his survival, served no therapeutic purpose beyond artificially prolonging his life.

The issues were: first, whether CANH administered through a PEG tube is medical treatment that may be withheld or withdrawn; second, whether passive euthanasia is permissible without an advance medical directive; third, whether continuing life-sustaining treatment in this case violated Article 21; and fourth, whether its continuation was in the patient's best interests.

The Court held that CANH is not ordinary feeding or basic care but a medical intervention involving an invasive procedure under clinical supervision, and therefore falls within the category of medical treatment; its withdrawal stands on the same footing as the withdrawal of mechanical ventilation. The Delhi High Court had erred in treating the absence of mechanical ventilation as decisive. In reaching this conclusion, the Court drew on comparative jurisprudence, including *Airedale NHS Trust v Bland*,[67] in which the House of Lords treated artificial nutrition and hydration as medical treatment, and on the principles of *Common Cause (2023)*.[68]

The Court held that passive euthanasia is permissible even without an advance medical directive, provided that the *Common Cause* safeguards are followed. Dignity, it held, is not confined to the conditions of living but extends to the process of dying, so that the right to life with dignity under Article 21 includes protection from treatment that offers no realistic prospect of recovery.

It applied a holistic, multi-factor best-interests test, weighing medical futility, the preservation of dignity, the patient's welfare and the views of the family. Since both Medical Boards had unanimously found that Harish was in an irreversible PVS and that CANH merely prolonged his life artificially, its continuation was not in his best

[67] *Airedale NHS Trust v Bland* [1993] AC 789 (HL).
[68] *Common Cause* (2023) (n 7).

interests. Judgment was delivered on 11 March 2026 by a Bench of Justice J B Pardiwala and Justice K V Viswanathan.

- **Directions and Outcome**

The Court permitted the withdrawal and withholding of all life-sustaining treatment, including CANH, and, since all stakeholders agreed, waived the thirty-day reconsideration period under the *Common Cause* guidelines. It directed AIIMS, New Delhi, to admit Harish to its palliative care department and to carry out the withdrawal under a palliative and end-of-life care plan that preserved his comfort and dignity.

It further directed the High Courts to instruct Judicial Magistrates of First Class to receive intimations from hospitals whenever the Primary and Secondary Medical Boards unanimously decide to withdraw or withhold treatment, and directed that the Chief Medical Officer of every district maintain a panel of registered medical practitioners for nomination to Secondary Medical Boards, to be reviewed at least every twelve months.

Describing its directions as an interim arrangement, the Court urged the enactment of comprehensive legislation on end-of-life care.[69] In a separate concurring opinion, Justice Viswanathan acknowledged the family's long ordeal and described their decision as an act of profound compassion and courage.[70]

Harish Rana died at AIIMS, New Delhi, on 24 March 2026.[71] As the first case in which the *Common Cause* framework was applied to authorise the withdrawal of treatment, it shows that the framework is workable, but also that relief came only after years of litigation, which underlines the need for a statute.

[69] *Harish Rana* (n 3) [327].
[70] *Harish Rana* (n 3) (K V Viswanathan J, concurring).
[71] 'Harish Rana, First Individual in India to Receive Legal Approval for Passive Euthanasia, Passes Away at AIIMS' (*News on AIR*, 24 March 2026) <https://www.newsonair.gov.in/harish-rana-first-individual-in-india-to-receive-legal-approval-for-passive-euthanasia-passes-away-at-aiims>.

Commentators have also observed that the best-interests test lacks clear evidentiary thresholds and a hierarchy among its factors, and that the judgment does not engage substantively with the Rights of Persons with Disabilities Act, 2016 or the UN Convention on the Rights of Persons with Disabilities, so that disability-rights concerns remain only partly addressed.[72]

E. Legislative and Policy Developments

The case for legislation has a long history. In its 196th Report (2006), the Law Commission of India recommended a statute permitting the withholding or withdrawal of life-sustaining treatment from terminally ill patients, subject to safeguards.[73] After *Aruna Shanbaug*, its 241st Report, *Passive Euthanasia – A Relook* (2012), again recommended legislation and proposed a revised Bill.[74] In 2016, the Union Ministry of Health and Family Welfare published the draft Medical Treatment of Terminally Ill Patients (Protection of Patients and Medical Practitioners) Bill, 2016 for public comment, but it was never introduced in Parliament.[75]

In September 2024, the Ministry released draft Guidelines for Withdrawal of Life Support in Terminally Ill Patients, under which life support may be withdrawn where the patient has been declared brainstem dead, or is unlikely to benefit from aggressive treatment, and the patient or surrogate has documented an informed refusal; the decision must be reached by a Primary Medical Board and validated by a Secondary Medical Board. These guidelines remain a draft.[76]

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[72] Raghav Sengupta, 'Dignity at the End: Analysing the Indian Supreme Court's First Judicially Sanctioned Passive Euthanasia Order' (*Verfassungsblog*, 28 March 2026) <https://verfassungsblog.de/harish-rana-v-union-of-india/>.
[73] Law Commission of India, *Medical Treatment to Terminally Ill Patients (Protection of Patients and Medical Practitioners)* (Report No 196, 2006).
[74] Law Commission of India, *Passive Euthanasia – A Relook* (Report No 241, 2012).
[75] Ministry of Health and Family Welfare, Draft Medical Treatment of Terminally Ill Patients (Protection of Patients and Medical Practitioners) Bill 2016 (released for public comment, May 2016).
[76] Directorate General of Health Services, Ministry of Health and Family Welfare, 'Draft Guidelines for Withdrawal of Life Support in Terminally Ill Patients' (September 2024).

At the State level, Karnataka's Health and Family Welfare Department issued an order on 30 January 2025 to implement *Common Cause*, providing for primary and secondary medical boards in hospitals, with one member of the secondary board nominated by the District Health Officer, and for the custody of advance medical directives.[77] Finally, in *Harish Rana* the Supreme Court itself urged comprehensive legislation.[78] These developments show that, nearly two decades after the Law Commission's first report, end-of-life decisions in India still rest on judicial guidelines and executive instruments rather than on a statute, and they form the basis of the recommendations made below.

VII. ARGUMENTS FOR AND AGAINST THE RIGHT TO DIE WITH DIGNITY

A. Arguments In Favour

1. Supporters argue that an individual knows best what is in his or her own interests and should therefore be able to decide whether to accept or refuse life-prolonging treatment, a view reflected in the recognition of self-determination in *Common Cause*.[79]

2. Where a patient is in severe and irremediable suffering, supporters argue that withdrawing futile treatment allows death with dignity and without prolonged suffering. Indian law permits this only in the form of passive euthanasia, subject to safeguards.[80]

3. Supporters argue that if the Constitution protects a dignified life, it should also protect a dignified death. The law accepts this only in part: *Common Cause* recognised a right to die with dignity in the limited sense of refusing or

[77] Government of Karnataka, Health and Family Welfare Department, Order dated 30 January 2025, implementing *Common Cause* (2023) (n 7).
[78] *Harish Rana* (n 3).
[79] *Common Cause* (2018) (n 1); *Schloendorff* (n 34).
[80] *Common Cause* (2018) (n 1); *Common Cause* (2023) (n 7).

withdrawing life-prolonging treatment, while *Gian Kaur* held that Article 21 does not include a general right to die.[81]

4. Prolonged and unbearable agony can make the experience of dying deeply distressing; supporters therefore regard the withdrawal of futile treatment, combined with palliative care, as an appropriate choice in such cases.[82]
5. Supporters regard death as an individual's private concern, in which the State and others should not intervene unless others are harmed, an argument grounded in the privacy and decisional autonomy recognised in *Puttaswamy*.[83]
6. For patients with no possibility of recovery, supporters contend that passive euthanasia is the only means of ending life with dignity, and that prolonging such a life by artificial means may itself offend dignity.[84]
7. Some supporters argue that a separate 'right to die' is unnecessary, because the right to refuse treatment already follows from the rights to bodily integrity and autonomy.[85]
8. Supporters also point to the cost of prolonged life-sustaining treatment for patients with no chance of recovery, arguing that scarce medical resources could be better used for patients who can benefit. This argument is contested, since the decisions recognised by the courts turn on medical futility and the patient's best interests rather than on cost.[86]
9. Supporters further note the emotional and financial burden on families who care for a patient in a persistent vegetative state for many years, as the long ordeal of the Rana family illustrates.[87]

[81] *Common Cause* (2018) (n 1); *Gian Kaur* (n 2).
[82] Mani and others (n 29).
[83] *Puttaswamy* (n 40).
[84] *Harish Rana* (n 3).
[85] *Samira Kohli* (n 35); *Common Cause* (2018) (n 1).
[86] *Harish Rana* (n 3); Sebastian (n 8).
[87] *Harish Rana* (n 3) (K V Viswanathan J, concurring).

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B. Arguments Against

1. Opponents invoke the Hippocratic tradition, which obliges doctors to preserve life, and argue that doctors should not be party to ending it. Indian law, however, does not require doctors to continue futile treatment at any cost: *Common Cause* and *Harish Rana* treat the withdrawal of futile treatment, under safeguards, as lawful and consistent with medical ethics. The objection therefore applies with full force only to active euthanasia.[88]
2. Religious beliefs lead many people to regard euthanasia as immoral and unethical, even sinful.[89]
3. Opponents argue that euthanasia compromises society's commitment to the sanctity of life.[90]
4. Opponents argue that advances in medical science and palliative care reduce the need for any patient to choose death.[91]
5. If encouraged or promoted, euthanasia could be abused as a cover for suicide or homicide; the Union opposed living wills before the Supreme Court in *Common Cause* precisely because of the risk of misuse.[92]
6. Opponents argue that euthanasia may harm society and the doctor-patient relationship, which rests on mutual trust that could be eroded if euthanasia were legalised.[93]
7. Opponents warn of a 'slippery slope': euthanasia may initially be permitted only for the terminally ill, but over time the law may change so that it becomes

[88] *Common Cause* (2018) (n 1); *Harish Rana* (n 3).
[89] *Catechism of the Catholic Church* (n 15); D Keown (n 17).
[90] John Keown, *Euthanasia, Ethics and Public Policy: An Argument Against Legalisation* (2nd edn, CUP 2018).
[91] Myatra and others (n 30).
[92] *Common Cause* (2018) (n 1).
[93] J Keown (n 88).

acceptable on non-voluntary or involuntary grounds, and vulnerable persons may feel pressured to choose it.[94]

8. Organisations representing persons with disabilities oppose the decriminalisation of euthanasia on the ground that such persons may feel compelled to choose death because they see themselves as a burden on society.[95] Commentators have raised similar concerns about the breadth of the best-interests test applied in *Harish Rana*.[96]

9. Many religious traditions hold that life is a gift from God, that no human being may assume the role of God, and that euthanasia therefore devalues human life.[97]

10. Opponents argue that medical ethics require nursing, care and recovery rather than ending a patient's life, and that patients should instead be supported through palliative care. This concern is reflected in Regulation 6.7 of the 2002 Regulations, which treats the practice of euthanasia as unethical conduct.[98]

11. A request for euthanasia may not always be the patient's own: family members or others may exert pressure for personal gain, such as to obtain the patient's property. This is why the *Common Cause* guidelines require that an advance directive be executed voluntarily and without coercion or undue influence, and that decisions be scrutinised by medical boards.[99]

[94] Law Commission, Report No 196 (n 71); J Keown (n 88).
[95] J Keown (n 88).
[96] Sengupta (n 70).
[97] *Catechism of the Catholic Church* (n 15); Bilimoria (n 10).
[98] Indian Medical Council Regulations 2002, reg 6.7 (n 53).
[99] *Common Cause* (2018) (n 1); *Common Cause* (2023) (n 7).

VIII. RECOMMENDATIONS AND CONCLUSION

A. Recommendations

1. **Comprehensive statute:** Parliament should enact a comprehensive law on end-of-life decisions, as the Supreme Court urged in *Harish Rana*, codifying the *Common Cause* safeguards, the treatment of CANH as medical treatment, a best-interests test with clear evidentiary thresholds, and protection for doctors who act in good faith within the law. The Law Commission's 196th and 241st Reports and the 2024 draft guidelines provide a starting point.
2. **National register of advance directives:** A national digital register of advance medical directives, linked to patients' digital health records, should be established, together with public awareness campaigns on living wills.
3. **Institutional capacity:** Hospitals should be required to constitute Primary Medical Boards; district panels of doctors for Secondary Medical Boards should be maintained as directed in *Harish Rana*; and doctors, Board members and Judicial Magistrates should be trained in the procedure.
4. **Palliative care:** Access to palliative care should be expanded, including in public hospitals and rural areas, so that no patient opts for the withdrawal of treatment for want of pain relief, and financial assistance should be available to families caring for terminally ill patients.
5. **Safeguards for the vulnerable:** The law should include safeguards against coercion and undue influence, independent review of decisions taken without an advance directive, and specific protections for persons with disabilities consistent with the Rights of Persons with Disabilities Act, 2016.
6. **Active euthanasia:** Any future consideration of active euthanasia or physician-assisted dying should be left to Parliament after wide public consultation; until then, lawful end-of-life decisions should remain confined to the withholding and withdrawal of futile treatment under the prescribed safeguards.

B. Conclusion

A more balanced understanding of dignity, autonomy and compassionate end-of-life care has gradually replaced the strong emphasis on the sanctity of life in India's euthanasia law. Article 21 of the Constitution has been construed over time to include both the right to live with dignity and, under certain conditions, the right to die with dignity. This changing constitutional understanding is demonstrated by the judicial path from *Maneka Gandhi*, *Francis Coralie Mullin* and *Puttaswamy*, through *P Rathinam* and *Gian Kaur*, to *Aruna Shanbaug*, *Common Cause* and, most recently, *Harish Rana*.

However, an unrestricted right to die is not recognised by Indian law. While passive euthanasia is accepted under certain legal and medical restrictions, active euthanasia is still prohibited. By enabling people to communicate their preferences for future medical care, the acceptance of living wills and advance medical directives reinforces the idea of patient autonomy.

Strong precautions are also necessary because of the potential for coercion, abuse and financial strain, and the vulnerability of terminally ill patients. A comprehensive legislative framework regulating end-of-life decisions is therefore urgently needed, as the Law Commission recommended as early as 2006 and as the Supreme Court urged in *Harish Rana*. Ultimately, the goal should be to preserve life where meaningful recovery is feasible, while ensuring that a person's dignity is not taken away by medically futile care. The promise of Article 21 of the Constitution must thus encompass both living and dying with dignity.

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