



**YourLawArticle**

Open Access Law Journal, ISSN (O): 3049-0057

Editor-in-Chief – Prof. (Dr.) Amit Kashyap; Publisher – Reet Parihar

**The Last Right: Right To Die With Dignity As An Evolution Of Article 21 In India**

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Published on: 12<sup>th</sup> June 2026

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***Abstract***

*This research paper seeks to critically examine the evolution of euthanasia jurisprudence in India, with particular emphasis on the constitutional interpretation of Article 21 and its expansion to include the “last right”, the right to die with dignity. It analyses the doctrinal developments through key judicial decisions, evaluates the legal and ethical implications of passive euthanasia and assesses the impact of the Harish Rana judgment in shaping the future of end-of-life decision-making in India. The paper argues that the recognition of this right does not undermine the sanctity of life; rather, it strengthens the constitutional commitment to human dignity by ensuring that life is not reduced to mere biological survival devoid of meaning, autonomy and respect.*

***Keywords: Right to Die with Dignity, Article 21, Passive Euthanasia, Human Dignity, Living Will, Advance Directives, Medical Futility, Personal Autonomy, Constitutional Law, End-of-Life Decisions, Human Rights, Healthcare Law***

## Introduction

*Sometimes life continues only as a mechanical act of breathing and existence goes on but the essence of living is already lost.*

This haunting sentiment is beautifully captured in the verse of Mirza Ghalib, where death is longed for, yet endlessly delayed. The same emotional and philosophical tension lies at the heart of *Harish Rana v. Union of India*. In this case, the Supreme Court advanced India's passive euthanasia jurisprudence by giving practical shape to the "right to die with dignity" under Article 21, building upon earlier rulings like *Aruna Shanbaug v. Union of India* and *Common Cause v. Union of India*. The Court recognised that compelling a person to remain alive in an irreversible condition, sustained only by artificial means, may violate their dignity. Much like Ghalib's verse, the judgment acknowledges a painful reality — when death becomes an awaited relief that never arrives, the law must respond with compassion, ensuring that dignity is preserved not only in life but also in the process of dying.

The right to life under Article 21 of the Constitution of India has evolved from a narrow textual guarantee into one of the most dynamic and expansive provisions in constitutional jurisprudence. Initially interpreted as mere protection against arbitrary deprivation of life and personal liberty, Article 21 has, through judicial creativity, grown to encompass a wide spectrum of rights that give substantive meaning to human existence, including the right to live with dignity, the right to privacy, the right to health and the right to bodily autonomy. Within this transformative constitutional framework, an important and deeply sensitive question has emerged—whether the right to life also includes the right to die with dignity, particularly in circumstances where continued existence is marked by irreversible suffering, terminal illness or a persistent vegetative state.

The issue of euthanasia, therefore, lies at the intersection of law, ethics, medicine and human rights. It raises complex dilemmas concerning the sanctity of life on one hand and the autonomy of the individual on the other. While traditional legal thought in India treated life as inviolable and placed an absolute prohibition on any form of life termination, contemporary constitutional interpretation has begun to recognize that the quality of life, rather than mere biological existence, is central to the meaning of Article 21. The question is no longer confined to whether life should be preserved at all costs, but whether the law should permit the withdrawal of artificial life support when such continuation only prolongs suffering without any reasonable hope of recovery.

Indian jurisprudence on euthanasia has developed gradually through a series of landmark judicial pronouncements. Beginning with *Gian Kaur v. State of Punjab (1996)*, where the Supreme Court

rejected the existence of a fundamental right to die but acknowledged the importance of dignity in the process of death, the law moved forward with *Aruna Shanbaug v. Union of India (2011)*, which for the first time permitted passive euthanasia under strict judicial supervision. This progression reached a constitutional milestone in *Common Cause v. Union of India (2018)*, where the Supreme Court explicitly recognized the right to die with dignity as an intrinsic part of Article 21 and legalized advance directives or living wills. However, despite this recognition, the practical enforcement of this right remained limited and largely theoretical due to procedural complexities and the absence of concrete application.

It is in this context that the recent decision in *Harish Rana v. Union of India (2026)* assumes profound significance. The case represents a decisive shift from abstract constitutional recognition to real-world implementation of the right to die with dignity. By permitting the withdrawal of life-sustaining treatment for a patient in a persistent vegetative state, the Supreme Court not only reaffirmed earlier principles but also simplified procedural safeguards and emphasized the role of medical expertise and family consent. This judgment marks a critical moment in Indian legal history, as it operationalizes the concept of passive euthanasia and reinforces the idea that dignity must extend to the final stages of life.

### **Conceptual Framework to Understand Euthanasia**

Euthanasia, often described as “mercy killing,” refers to the intentional act or omission that results in the termination of a person’s life with the primary objective of relieving intractable pain, suffering or irreversible medical conditions. The term is derived from the Greek words *eu* meaning “good” and *thanatos* meaning “death,” collectively signifying a “good death” or a death free from suffering. In legal and medical discourse, euthanasia is not a monolithic concept but encompasses various forms distinguished on the basis of intent, method and consent. Broadly, it is classified into active and passive euthanasia. Active euthanasia involves a deliberate act, such as administering a lethal injection, to cause death and is generally considered illegal in India as it directly amounts to culpable homicide. Passive euthanasia, on the other hand, involves the withdrawal or withholding of life-sustaining treatment, such as ventilators, feeding tubes or life-support systems, thereby allowing the patient to die naturally. It is this form that has gradually gained limited legal recognition in India under strict safeguards.

The conceptual distinction between active and passive euthanasia is central to legal analysis, as it reflects the moral and constitutional difference between “killing” and “letting die.” While active euthanasia is perceived as a direct intervention to end life, passive euthanasia is often justified as

permitting the natural process of death to take its course when medical intervention serves no meaningful purpose. This distinction becomes particularly significant in cases involving terminal illness or patients in a persistent vegetative state, where continued treatment may merely prolong biological existence without any prospect of recovery or conscious experience. In such situations, the continuation of life-support measures raises important questions about medical futility and the ethical responsibility of healthcare providers.

Another important dimension of euthanasia relates to the element of consent, which determines whether the act is voluntary, non-voluntary or involuntary. Voluntary euthanasia occurs when a competent patient makes an informed decision to refuse treatment or requests withdrawal of life support. Non-voluntary euthanasia arises in situations where the patient is incapable of expressing consent, such as in cases of coma or severe cognitive impairment and decisions are taken by family members or medical authorities based on the patient's best interests. Involuntary euthanasia, which involves ending a life without the patient's consent despite their capacity to decide, is universally condemned and treated as a criminal act. The Indian legal framework primarily engages with voluntary and non-voluntary passive euthanasia, particularly through the recognition of advance directives or living wills, which enable individuals to exercise autonomy over end-of-life decisions even in situations of incapacity.

From an ethical standpoint, euthanasia is situated at the intersection of competing principles such as the sanctity of life, individual autonomy, beneficence and non-maleficence. The principle of sanctity of life emphasizes the inherent value of human existence and supports the idea that life must be preserved at all costs. In contrast, the principle of autonomy upholds the individual's right to make decisions regarding their own body, including the refusal of medical treatment. The principles of beneficence and non-maleficence require medical professionals to act in the best interests of the patient and to avoid causing harm, which in certain circumstances may justify the withdrawal of treatment that only prolongs suffering. Thus, euthanasia presents a delicate balance between preserving life and respecting dignity, compelling the law to reconcile these competing values within a constitutional framework.

In the Indian context, the conceptual understanding of euthanasia has evolved from a rigid prohibition rooted in criminal law to a more nuanced recognition shaped by constitutional principles. While active euthanasia continues to be prohibited, passive euthanasia has been conditionally permitted through judicial pronouncements, reflecting a shift towards acknowledging dignity and autonomy at the end of life. This evolving framework underscores the need to view euthanasia not

merely as an act of ending life, but as a complex legal and ethical issue that engages fundamental questions about human dignity, suffering and the role of the State in regulating life and death.

## **Evolution of Euthanasia Jurisprudence in India**

### **1. *Gian Kaur v. State of Punjab (1996)***

The foundation of euthanasia jurisprudence in India was laid in *Gian Kaur v. State of Punjab (1996)*<sup>1</sup>, where the Supreme Court was called upon to determine whether the “right to die” could be read into Article 21 of the Constitution. The Court unequivocally held that the right to life does not include the right to die, thereby upholding the constitutional validity of Section 306 of the Indian Penal Code, which criminalizes abetment of suicide. However, the judgment made a crucial observation that significantly influenced later jurisprudence: the Court acknowledged that the right to life includes the right to live with human dignity and this dignity extends up to the point of natural death. It further recognized that in cases of terminal illness or a persistent vegetative state, the process of natural death may already have commenced, thereby opening the door for future legal acceptance of passive euthanasia. Thus, although the Court rejected the notion of a “right to die,” it subtly laid the conceptual groundwork for recognizing a dignified death as part of Article 21.

### **2. *Aruna Ramachandra Shanbaug v. Union of India (2011)***

A significant turning point in Indian euthanasia law came with the decision in *Aruna Ramachandra Shanbaug v. Union of India (2011)*<sup>2</sup>. The case involved a nurse who had remained in a persistent vegetative state for over four decades following a brutal assault. The Supreme Court, while rejecting the plea for active euthanasia, for the first time allowed passive euthanasia under strict conditions. The Court distinguished between active euthanasia, which it held to be illegal and passive euthanasia, which it permitted in exceptional circumstances involving withdrawal of life-sustaining treatment. Importantly, the Court introduced a procedural safeguard requiring approval from the concerned High Court before any such decision could be implemented. It also emphasized that such decisions must be based on the “best interests of the patient,” rather than solely on the wishes of family members. This judgment marked the first formal recognition of passive euthanasia in India and established a judicial framework for its limited application.

### **3. *Common Cause v. Union of India (2018)***

<sup>1</sup> *Gian Kaur v State of Punjab (1996) 2 SCC 648.*

<sup>2</sup> *Aruna Ramachandra Shanbaug v Union of India (2011) 4 SCC 454.*

The jurisprudence surrounding euthanasia was significantly expanded in *Common Cause v. Union of India (2018)*<sup>3</sup>, where a Constitution Bench of the Supreme Court firmly recognized the right to die with dignity as a fundamental right under Article 21. The Court held that an individual has the right to refuse medical treatment, including life-sustaining treatment, thereby affirming personal autonomy and bodily integrity. One of the most important contributions of this judgment was the legal recognition of “advance directives” or “living wills,” which allow individuals to specify their preferences regarding end-of-life care in case they become incapable of making decisions in the future. The Court also laid down detailed guidelines governing the execution and implementation of such directives, including the constitution of medical boards and procedural safeguards to prevent misuse. This decision transformed the legal position from conditional judicial permission to a constitutionally protected right, thereby giving substantive content to the concept of dignified death.

#### **4. *Harish Rana v. Union of India (2026)***

The most recent and transformative development in this jurisprudential journey is the decision in *Harish Rana v. Union of India (2026)*, which represents the first real and practical application of the principles laid down in *Common Cause*. The case involved a young man who had been in a persistent vegetative state for several years with no prospect of recovery. His family approached the Court seeking permission to withdraw life-sustaining treatment. The Supreme Court, relying on prior precedents and medical evidence, allowed passive euthanasia and permitted the withdrawal of artificial life support. The Court emphasized that prolonging life in a state devoid of consciousness and dignity amounts to an unjustified extension of suffering. It further streamlined the procedural requirements by reducing excessive judicial intervention and placing greater reliance on medical boards and family consent. This judgment is significant because it moves beyond theoretical recognition and demonstrates the enforceability of the right to die with dignity in real-life situations. It reinforces the idea that Article 21 protects not merely the existence of life but the quality and dignity associated with it, even at its end.

The decision in *Harish Rana v. Union of India (2026)* marks a pivotal moment in the evolution of euthanasia jurisprudence in India, as it represents the first concrete and practical implementation of the right to die with dignity recognized in earlier constitutional decisions. The case revolved around Harish Rana, a young man who had been in a persistent vegetative state since 2013 following a severe head injury. For over a decade, he remained dependent on life-sustaining medical support,

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<sup>3</sup> *Common Cause (A Regd Society) v Union of India (2018) 5 SCC 1.*

with no signs of cognitive recovery or improvement in his condition. His prolonged medical state raised profound questions regarding the continuation of artificial life support in situations where consciousness, awareness and the possibility of recovery are effectively absent.

In 2024, Harish Rana's father approached the Delhi High Court seeking permission for the withdrawal of life-sustaining treatment, arguing that the continued medical intervention merely prolonged suffering without serving any therapeutic purpose. However, the High Court declined to grant such permission, reflecting the cautious approach traditionally adopted by courts in matters involving end-of-life decisions. Consequently, the matter was escalated to the Supreme Court, which undertook a detailed examination of the medical evidence, constitutional principles and prior judicial precedents governing passive euthanasia.

During the proceedings, multiple medical boards were constituted to assess the patient's condition. These expert bodies unanimously concluded that Harish Rana's condition was irreversible and that there was no reasonable possibility of recovery. The medical findings emphasized that continued life-support measures would not restore consciousness or improve his quality of life, thereby bringing the case within the domain of medical futility. This medical consensus played a crucial role in guiding the Court's determination, as it underscored that the continuation of treatment would serve no curative or rehabilitative purpose.

Relying on the constitutional principles laid down in *Common Cause v. Union of India (2018)* and earlier precedents, the Supreme Court ultimately allowed the withdrawal of life-sustaining treatment. The Court directed that the process be carried out under strict medical supervision and in accordance with established procedural safeguards to ensure that the decision was implemented in a humane, transparent and ethically sound manner. Importantly, the Court emphasized that the objective was not to hasten death, but to allow the natural process of dying to take its course with dignity, free from unnecessary medical intervention that only prolongs biological existence without meaningful life.

This judgment is widely regarded as the first real and effective application of passive euthanasia in India, moving beyond theoretical recognition to practical enforceability. It reaffirmed that the right to die with dignity is not merely a conceptual extension of Article 21, but a legally enforceable right that can be invoked in appropriate circumstances. Furthermore, the Court clarified several important legal principles that will guide future cases. It established that the right to die with dignity is an integral part of the right to life and is therefore enforceable within the constitutional framework. It recognized that medical futility—where treatment offers no real prospect of recovery—constitutes a valid ground for the withdrawal of life-sustaining measures. The judgment also underscored the

importance of family consent in conjunction with expert medical opinion, thereby ensuring that decisions are both compassionate and clinically justified. Significantly, the Court indicated that excessive judicial intervention may not be necessary in every case, thereby streamlining the process and reducing procedural delays.

In essence, *Harish Rana v. Union of India* bridges the gap between constitutional theory and medical reality. It reinforces the idea that dignity is not confined to the conditions of living but extends to the manner of dying, thereby completing the constitutional promise of Article 21. The case stands as a milestone in Indian legal history, shaping the future discourse on euthanasia and end-of-life decision-making by prioritizing human dignity, autonomy and compassion.

#### **4. Constitutional Analysis: Article 21 and the “Last Right”**

The constitutional foundation of the right to die with dignity in India is rooted in the expansive interpretation of Article 21, which guarantees the right to life and personal liberty. Over the years, the Supreme Court has transformed Article 21 from a narrowly construed protection against arbitrary deprivation of life into a comprehensive source of substantive human rights. This evolution has led to the recognition that the right to life is not confined to mere physical survival but includes the right to live with dignity, autonomy and self-respect. Within this broadened framework, several derivative rights have emerged, including the right to privacy, as affirmed in *Justice K.S. Puttaswamy v. Union of India (2017)*<sup>4</sup>, the right to bodily autonomy and the right to make informed decisions regarding one’s own body and medical treatment. The recognition of the right to refuse medical treatment, particularly in cases of terminal illness or irreversible conditions, logically extends from these principles. Consequently, the right to die with dignity is increasingly understood not as a contradiction of the right to life, but as its natural and inevitable extension, ensuring that life retains its qualitative essence even at its final stage.

Central to this constitutional interpretation is the concept of dignity, which has been consistently upheld by the Supreme Court as the core value underlying Article 21. The Court has repeatedly emphasized that life devoid of dignity is not worth living and that the Constitution seeks to protect not only the existence of life but also its quality. In this context, forcing an individual to endure prolonged suffering through artificial life-support systems, particularly when recovery is medically impossible, may amount to a violation of dignity rather than its preservation. The decision in *Harish Rana v. Union of India (2026)* reinforces this understanding by clarifying that the objective of

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<sup>4</sup> Justice KS Puttaswamy (Retd) v Union of India (2017) 10 SCC 1.

permitting passive euthanasia is not to terminate life prematurely, but to prevent the unnecessary and artificial prolongation of suffering. The Court drew a crucial distinction between causing death and allowing the natural process of dying to occur with dignity, thereby aligning constitutional principles with ethical and medical realities.

Another important dimension of this analysis lies in distinguishing between negative and positive rights within the framework of Article 21. The right to die with dignity is conceptualized as a negative right, meaning that it encompasses the individual's freedom to refuse or discontinue medical treatment that sustains life artificially. It does not, however, extend to a positive right to actively seek or demand death through deliberate intervention. This distinction is essential in maintaining the constitutional balance between individual autonomy and the State's interest in preserving life. By recognizing passive euthanasia while continuing to prohibit active euthanasia, the Indian legal system adopts a calibrated approach that respects personal liberty without undermining the sanctity of life. Thus, the "last right" emerges as a carefully structured constitutional principle that harmonizes dignity, autonomy and ethical restraint, ensuring that the right to life under Article 21 remains both meaningful and humane in its application.<sup>5</sup>

### **5. Role of Medical Boards and Safeguards**

The recognition of the right to die with dignity in India has been accompanied by the establishment of a robust framework of procedural safeguards, primarily aimed at preventing misuse and ensuring that decisions regarding withdrawal of life-sustaining treatment are taken with utmost care, transparency and accountability. The Supreme Court, particularly in *Common Cause v. Union of India (2018)* and reaffirmed in *Harish Rana v. Union of India (2026)*, has emphasized the necessity of institutional mechanisms to balance individual autonomy with the State's duty to protect life. Central to this framework is the role of medical boards, which function as expert bodies responsible for evaluating the medical condition of the patient and determining whether continued treatment serves any meaningful purpose. The Court has mandated the constitution of both primary and secondary medical boards, comprising qualified and experienced medical practitioners, to independently assess the patient's condition. These boards are required to conduct a thorough examination and provide an objective opinion regarding the irreversibility of the illness and the futility of further treatment. Such multi-layered medical evaluation ensures that the decision to withdraw life support is not arbitrary or influenced by extraneous considerations, but is grounded in

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<sup>5</sup> Constitution of India, art 21.

sound medical judgment. Additionally, strict procedural compliance is required at every stage, including proper documentation, verification and adherence to prescribed guidelines, thereby reinforcing the legitimacy and reliability of the decision-making process.

Another significant safeguard recognized within this framework is the concept of living wills or advance directives, which empowers individuals to exercise autonomy over their end-of-life decisions. First formally acknowledged in *Common Cause* and subsequently reaffirmed in *Harish Rana*, advance directives allow a person, while still competent, to specify the circumstances under which they would not wish to receive life-sustaining treatment in the future. This mechanism ensures that an individual's preferences are respected even when they are no longer in a position to communicate or make decisions due to incapacitation. By giving legal recognition to such directives, the Court has strengthened the principle of self-determination and reinforced the idea that personal autonomy extends beyond the active phases of life into its final stages. At the same time, the implementation of living wills is subject to procedural safeguards, including authentication, verification by medical authorities and compliance with prescribed formats, to ensure their genuineness and prevent potential abuse.

The framework also incorporates multiple layers of protection to guard against misuse, particularly in a socio-economic context like India where vulnerabilities such as financial constraints, familial pressures and lack of awareness may influence decision-making. The requirement of multiple medical opinions acts as a critical check, ensuring that no single individual or authority can unilaterally decide on matters involving life and death. Detailed documentation requirements further enhance transparency by creating a clear record of the decision-making process, including medical assessments, consent of family members and compliance with legal procedures. Ethical oversight, whether through hospital ethics committees or adherence to professional medical standards, provides an additional layer of scrutiny to ensure that decisions are guided by compassion and medical necessity rather than convenience or external pressures.

Thus, the role of medical boards and procedural safeguards is indispensable in operationalizing the right to die with dignity. These mechanisms ensure that while the law recognizes the autonomy and dignity of the individual, it simultaneously maintains adequate checks to prevent arbitrary or unethical practices. By striking this balance, the Indian legal framework seeks to uphold both the sanctity of life and the dignity of death, ensuring that end-of-life decisions are made with sensitivity, responsibility and constitutional fidelity.

## **6. Comparative Jurisprudence**

A comparative analysis of euthanasia laws across different jurisdictions provides valuable insight into how legal systems reconcile the competing values of individual autonomy, medical ethics and the sanctity of life. Countries such as the Netherlands and Belgium represent some of the most liberal approaches to euthanasia, having legalized both active and passive forms under comprehensive statutory frameworks. In the Netherlands, the *Termination of Life on Request and Assisted Suicide (Review Procedures) Act, 2002* permits physicians to actively end a patient’s life or assist in suicide, provided that strict conditions are fulfilled, including voluntary and well-considered consent, unbearable suffering with no prospect of improvement and mandatory consultation with independent medical professionals. Similarly, Belgium legalized euthanasia through the *Belgian Act on Euthanasia, 2002*, which allows both active euthanasia and physician-assisted death under rigorous procedural safeguards. These jurisdictions emphasize transparency, accountability and medical oversight, thereby institutionalizing euthanasia as a regulated medical practice rather than an exceptional legal allowance.<sup>6</sup>

In contrast, the United States adopts a more cautious and fragmented approach, wherein euthanasia in the form of active intervention remains illegal, but physician-assisted dying is permitted in certain states such as Oregon, Washington and California under “Death with Dignity” laws. These statutes allow terminally ill patients to request and self-administer prescribed medication to end their lives, subject to strict eligibility criteria, including mental competence, voluntary consent and confirmation by multiple physicians. The American model places significant emphasis on patient autonomy and informed choice, while simultaneously imposing safeguards to prevent coercion and misuse. Importantly, the decentralized nature of the U.S. legal system results in significant variation across states, reflecting differing societal, ethical and political attitudes towards end-of-life decision-making.

India, in comparison, has adopted a balanced and cautious middle path that reflects its unique constitutional values, socio-cultural context and ethical considerations. While active euthanasia continues to be prohibited and is treated as a criminal offence, passive euthanasia has been judicially recognized and permitted under specific conditions through landmark decisions such as *Common Cause v. Union of India (2018)* and *Harish Rana v. Union of India (2026)*. The Indian approach does not endorse a direct intervention to end life but allows the withdrawal or withholding of life-sustaining treatment in cases of medical futility, thereby respecting both the sanctity of life and the dignity of the individual. This calibrated framework ensures that autonomy is recognized without

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<sup>6</sup> Belgian Act on Euthanasia 2002 (Belgium).

opening the door to potential misuse associated with active euthanasia. Moreover, the emphasis on procedural safeguards, medical evaluation and ethical oversight reflects a conscious attempt to adapt global principles to local realities.

Thus, India's position on euthanasia represents a nuanced synthesis of international practices, combining elements of autonomy and compassion with restraint and caution. By permitting passive euthanasia while prohibiting active measures, the Indian legal system seeks to maintain a delicate balance between individual rights and societal interests, ensuring that the evolution of euthanasia law remains aligned with constitutional morality and cultural sensibilities.

### **7. Ethical and Legal Challenges**

Despite the gradual recognition of the right to die with dignity within Indian constitutional jurisprudence, the legalization of passive euthanasia continues to raise significant ethical and legal challenges that cannot be overlooked. One of the most frequently invoked concerns is the "slippery slope" argument, which suggests that permitting even a limited form of euthanasia may eventually lead to its misuse or expansion beyond intended boundaries. Critics argue that once the law allows withdrawal of life-sustaining treatment in certain cases, it may become increasingly difficult to prevent its application in less extreme situations, thereby weakening the broader commitment to the sanctity of life. There is also a genuine apprehension that vulnerable groups, including the elderly, disabled or economically disadvantaged individuals, may be subjected to subtle coercion or undue influence by family members or caregivers who may view them as a burden. In such circumstances, the risk of abuse transforms euthanasia from an act of compassion into a potential instrument of exploitation, thereby necessitating stringent safeguards and continuous oversight.

Another critical challenge arises within the domain of medical ethics, where healthcare professionals are often placed in deeply conflicting positions. The traditional role of a doctor is guided by the Hippocratic Oath and the principle of preserving life, which may appear incompatible with any act that results in the cessation of life-support. At the same time, modern medical ethics also recognizes the principles of beneficence and non-maleficence, which require doctors to act in the best interests of the patient and to avoid causing unnecessary harm. In cases where medical treatment merely prolongs suffering without offering any hope of recovery, continuing such intervention may itself be considered a form of harm. This creates a moral dilemma for physicians, who must navigate between their duty to preserve life and their responsibility to alleviate suffering. The recognition of passive euthanasia attempts to resolve this tension by framing the withdrawal of treatment not as an act of

killing, but as allowing the natural process of death to occur with dignity; however, the ethical discomfort associated with such decisions persists within the medical community.

Furthermore, the socio-economic realities of India add another layer of complexity to the issue of euthanasia. Widespread poverty, unequal access to healthcare and the high cost of prolonged medical treatment may influence decisions regarding the withdrawal of life support. In some cases, families facing financial hardship may opt for discontinuation of treatment not purely on ethical or medical grounds, but due to economic constraints. This raises serious concerns about whether such decisions truly reflect the patient's best interests or are shaped by external pressures. Additionally, the lack of a well-developed palliative care infrastructure in India means that many patients do not have access to adequate pain management and end-of-life care, which could otherwise reduce the perceived need for euthanasia. Without strengthening palliative care systems and ensuring equitable access to healthcare, the legalization of passive euthanasia risks becoming a substitute for, rather than a complement to, compassionate medical care.

In light of these challenges, it becomes evident that while the right to die with dignity represents a significant advancement in constitutional law, its implementation must be approached with caution, sensitivity and a strong ethical framework. The law must continuously strive to strike a balance between respecting individual autonomy and protecting vulnerable populations, ensuring that the exercise of this right remains truly voluntary, informed and free from coercion. Only through such a balanced approach can the ideals of dignity, compassion and justice be meaningfully upheld in end-of-life decision-making.

#### **8. Need for Legislative Framework**

Despite the progressive recognition of the right to die with dignity by the Supreme Court through landmark judgments, India continues to lack a comprehensive statutory framework governing euthanasia and end-of-life decision-making. The current legal position is largely the result of judicial pronouncements, particularly *Common Cause v. Union of India (2018)* and *Harish Rana v. Union of India (2026)*, which have laid down guidelines for passive euthanasia and the execution of advance directives. While these decisions have played a crucial role in shaping the legal landscape, reliance on judicial law alone presents inherent limitations. Judge-made law, by its very nature, is case-specific and may lack the clarity, uniformity and accessibility that a codified legislative framework can provide. The absence of a clear statute creates ambiguity in implementation, leads to inconsistent practices across medical institutions and places an additional burden on courts and healthcare providers to interpret and apply evolving legal principles.

The distinction between judicial law and legislative law becomes particularly significant in a sensitive area such as euthanasia, which involves complex ethical, medical and social considerations. While the judiciary has acted as a catalyst in recognizing the constitutional dimensions of the right to die with dignity, it is ultimately the responsibility of the legislature to translate these principles into a comprehensive and detailed legal regime. Codification would provide greater certainty by clearly defining the scope of permissible actions, establishing standardized procedures and delineating the roles and responsibilities of medical professionals, patients and families. It would also help in creating uniform safeguards applicable across the country, thereby minimizing the risk of misuse and ensuring that the right is exercised in a fair and consistent manner.

In this context, there is an urgent need for the enactment of a dedicated “Euthanasia Regulation Act” that addresses the various dimensions of end-of-life care. Such legislation should lay down standardized medical protocols for assessing terminal illness and medical futility, including the constitution and functioning of medical boards. It should also provide a clear and simplified procedure for the execution and implementation of living wills or advance directives, ensuring that individuals can effectively exercise their autonomy without procedural hurdles. Furthermore, the law must incorporate robust safeguards, including documentation requirements, independent oversight mechanisms and penalties for misuse, to protect vulnerable individuals from coercion or exploitation.

Equally important is the need to strengthen the palliative care infrastructure in India, as the availability of quality end-of-life care can significantly reduce the perceived necessity for euthanasia. A comprehensive legislative framework should therefore integrate palliative care as an essential component of healthcare policy, ensuring that patients have access to adequate pain management and emotional support. In addition, public awareness initiatives must be undertaken to educate individuals about their rights, particularly the concept of living wills and the legal options available for end-of-life decision-making.

In essence, while judicial intervention has laid a strong constitutional foundation for the right to die with dignity, the absence of a statutory framework leaves this right incomplete and potentially inconsistent in its application. Legislative action is therefore indispensable to consolidate these developments, provide clarity and uniformity and ensure that the exercise of this “last right” is guided by a well-defined, transparent and ethically sound legal structure.

#### **10. Critical Evaluation of *Harish Rana v. Union of India* (2026)**

The decision in *Harish Rana v. Union of India (2026)* represents a significant advancement in Indian constitutional jurisprudence by translating the theoretical recognition of the right to die with dignity into a practical and enforceable reality. One of the most notable strengths of the judgment lies in its ability to humanize constitutional law by grounding abstract principles such as dignity, autonomy and liberty in real-life circumstances marked by suffering and medical futility. The Court moved beyond a purely doctrinal interpretation of Article 21 and acknowledged the lived experiences of patients and their families, thereby reinforcing the idea that constitutional rights must respond to human realities. Furthermore, the judgment provides much-needed practical implementation of the principles laid down in *Common Cause v. Union of India (2018)*<sup>7</sup>, which, until then, largely remained confined to theoretical recognition due to procedural complexities. By permitting the withdrawal of life-sustaining treatment based on medical evaluation and family consent, the Court has demonstrated that the right to die with dignity is not merely symbolic but capable of meaningful enforcement. Another important contribution of the decision is that it reduces the excessive burden on the judiciary by indicating that not every case requires prolonged judicial intervention, thereby streamlining the process and making it more accessible and efficient.

However, despite these progressive features, the judgment is not without its limitations. A primary concern is the continued absence of a comprehensive legislative framework governing euthanasia in India. The reliance on judicial pronouncements, while necessary in the absence of statutory law, results in a fragmented and evolving legal regime that may lack uniformity and clarity. The *Harish Rana* judgment, although progressive, does not fully resolve procedural ambiguities, particularly with respect to the exact scope of medical authority, the role of family consent and the extent of institutional oversight required in different scenarios. This lack of precise codification may lead to inconsistent application across hospitals and jurisdictions, thereby undermining the predictability and reliability of the law. Additionally, there remains a potential risk of misuse, especially in a socio-economic context where factors such as financial constraints or familial pressures may influence decision-making. Without clear statutory safeguards and regulatory mechanisms, the implementation of passive euthanasia may vary in practice, raising concerns about accountability and protection of vulnerable individuals.

Thus, while *Harish Rana v. Union of India*<sup>8</sup> marks a crucial step forward in operationalizing the right to die with dignity, it also highlights the urgent need for legislative intervention to consolidate and refine the existing framework. The judgment serves as both a milestone and a reminder that

<sup>7</sup> *Common Cause (A Regd Society) v Union of India (2018) 5 SCC 1.*

<sup>8</sup> *Harish Rana v Union of India 2026 SCC OnLine SC 358*

constitutional recognition must be complemented by statutory clarity to ensure consistent and equitable application.

## 11. Conclusion

The evolution of euthanasia jurisprudence in India, from *Gian Kaur v. State of Punjab (1996)* to *Harish Rana v. Union of India (2026)*, reflects a profound transformation in the interpretation of Article 21 and the broader understanding of human dignity within constitutional law. What began as a rigid rejection of the “right to die” has gradually developed into a nuanced recognition of the right to die with dignity, illustrating the dynamic and progressive nature of the Indian Constitution. This shift underscores the realization that dignity is not confined to the conditions of living but extends to the manner in which life ends, particularly in circumstances involving irreversible suffering and medical futility.

The concept of the “last right” must not be misconstrued as an endorsement of death over life; rather, it represents a commitment to preserving dignity over the mere prolongation of biological existence. The Supreme Court, through *Harish Rana v. Union of India*, has reaffirmed that the Constitution is a living document, capable of adapting to evolving social, medical and ethical realities with sensitivity and compassion. By recognizing the legitimacy of withdrawing life-sustaining treatment in appropriate cases, the Court has ensured that the right to life under Article 21 retains its qualitative essence, grounded in autonomy, respect and humanity.

However, the journey towards a coherent and effective euthanasia framework in India remains incomplete. The absence of comprehensive legislation continues to pose challenges in terms of clarity, uniformity and implementation. Without statutory backing, the right to die with dignity risks remaining unevenly applied and vulnerable to misuse or misinterpretation. It is therefore imperative for the legislature to step in and enact a well-defined legal framework that incorporates procedural safeguards, medical guidelines and ethical oversight mechanisms.

Ultimately, the recognition of the right to die with dignity completes the constitutional promise of Article 21 by ensuring that life, in all its stages—from existence to its inevitable end—is treated with equal respect and dignity. It affirms that the law must not only protect life but also ensure that it ends in a manner that is humane, meaningful and consistent with the values of a just and compassionate society.