

Passive Euthanasia and Article 21: Contemporary Legal, Moral, and Ethical Challenges to the Right to Die with Dignity

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Abstract

The constitutional puzzle arose because of Indian law on persons in the end of life. On the one hand, it must prevent the premature death of patients, while on the other hand, it must respect the patient's refusal of unburdening treatment. This article will observe how Article 21 tackles that challenge without allowing an unrestricted right to assisted death. By doctrinal analysis of Supreme Court rulings ending up in *Harish Rana v Union of India* in March 2026, it distinguishes between competent refusal, advance directives and best-interests decisions for non-communicating patients. As per this, procedural simplification may be necessary but not sufficient for meaningful autonomy; rather availability of information, independent clinical assessment, freedom from economic coercion and continuing palliative care is important. It is not “dignity vs the sanctity of life”, but whether either displaces the patient's own interest that is the core ethical question. A defensible framework must include safeguards tailored to the decision in question, express protection that the decision will not be made on the basis of disability, and institutional responsibility for care both before and after withdrawal of treatment.

Keywords: Article 21; passive euthanasia; advance directives; patient autonomy; best interests; palliative care.

Introduction

The term “right to die with dignity” often raises more questions than answers. This is a refusal of a treatment that is unwanted, or stopping a treatment with no relevant benefit, or an asserted entitlement to gain assistance in dying. Such claims cannot be exchanged. The right to life and personal liberty is guaranteed by Article 21.¹ Medical treatment is covered by Article 21, but it also takes into consideration a person’s² bodily integrity, the circumstance in which the patient is placed and the object of the intervention. The Supreme Court recognizes autonomy at the end-of-life is covered by this Constitution.

Acknowledge the technology and its responsible use- a cliché. In principle, a framework may safeguard autonomous choice, but it could then merely wreck it with formalism.³ On a more administrative convenience side, there should be more interrogatory on coercion, mistaken prognosis or conflict of interest. The article discusses the distinctions that Indian law draws between permissible withdrawal of treatment and an unlimited right-to-die. This has also generated a debate on whether sufficient safeguards are in place along with sufficient autonomy, equality and continued care. The methodology is doctrinal and normative; it studies leading judgments, distinguishes holdings from broader moral arguments and assesses institutional arrangements. The current goal is not that a ruling of 11 March 2026⁴ will be applied all over the country.

2. From the protection of life to treatment-related autonomy

2.1 The significance of *Gian Kaur* and *Aruna Shanbaug*

The Constitution Bench rejected the proposition in *Gian Kaur v State of Punjab*⁵ that Article 21 ensures the general right to terminate one’s life. However, it made a distinction between the termination of life and the dignity to die. The distinguished system was relevant to later on cases, but *Gau Kaur* did not actually establish the detailed authorisation procedure and different formalities. To read it as either an absolute prohibition on all refusals of treatment, or as a general permission for euthanasia, translates its holding too far.

The issue of treatment was brought into direct focus by *Aruna Ramachandra Shanbaug v Union of India*⁶. The Court created a route for passive euthanasia supervised by a High Court but refused the demand in *Aruna Shanbaug*. The combination was relevant: it was not because a legal category was accepted, that there was no individual examination. The patient's condition, caregivers’ evidence and the differences between medical interventions remained at the centre of cases. The judgment also showed how a highly protective judicial process can sanction a highly personal medical question becoming the subject of litigation.

2.2 *Common Cause*: recognition and procedural revision

In the *Common Cause v Union of India*⁷ de la Cour 2018, the Cour recognised the right to die with dignity in the end years context and gave legal effect to advance medical directives. In its reasoning, bodily autonomy was connected to the ability to refuse treatment, including by prior instruction if decision-making capacity is

¹ Constitution of India 1950, art 21.

² *Justice K S Puttaswamy (Retd) v Union of India* (2017) 10 SCC 1; *Common Cause v Union of India* (2018) 5 SCC 1.

³ *Common Cause v Union of India* (2023) 14 SCC 131.

⁴ *Harish Rana v Union of India* 2026 INSC 222.

⁵ *Gian Kaur v State of Punjab* (1996) 2 SCC 648.

⁶ *Aruna Ramachandra Shanbaug v Union of India* (2011) 4 SCC 454.

⁷ *Common Cause v Union of India* (2018) 5 SCC 1.

lost. The constitutional achievement didn't create a choice of death that is unfettered. The fact that the deficit of functional ability was medically intervened and enabled the patient to function where necessary.

The 2023 revision dealt with the practical burden of the directions. An advance directive can be attested by a notary or Gazetted Officer⁸ instead of being countersigned by a Judicial Magistrate First Class. The updated framework changed medical-board specifications, including the relevant experience threshold, while keeping independent levels of scrutiny. Any safeguards that seem not to guarantee real protection like an independent or agency body should not get equivalent signatures. A formality that interferes with a proper choice from being utilized may frustrate the right it supposedly protects.

The updated directives propose that the primary and secondary medical boards provide their input preferably within forty-eight hours⁹ of referral to each board. No less, clinical complexity does not excuse unexplained institutional delay. A documented justification of the decision, the evidence taken into account and whether further investigation is required reconciles urgency with caution better than either rubber-stamping or infinite delay.

3. *Harish Rana*: applying the framework to an incapacitated patient

The 2026 *Harish Rana* judgement dealt with the withdrawal of treatment including clinically assisted nutrition and hydration for a patient in PVS.¹⁰ The court viewed such assistance as medical treatment under the relevant regime, and permitted withdrawal in the established circumstances. This classification is important because the delivery of these products may be artificial and clinical, yet we call them food and water. The criteria for withdrawal have not been met by every assisted feeder.

The Court instructed access to the palliative care department of the All India Institute of Medical Sciences and a tailored end-of-life care plan.¹¹ The order further directed that a panel of qualified practitioners should be prepared and maintained at the district level for secondary medical boards.¹² The ruling related tailored assistance to the organization of the administration needed for the implementation of the earlier directions. A right may be enforceable but losing a board means that it has little utility. In effect, the existence of a right does not make it available in practice.

However, a limit is established by this litigation. One Patient's Withdrawal Authorization Order Doesn't Indicate Every Hospital's Ability To Perform Procedure Or That All States Have Complied With Directions A profound dependence will not lead to a diminishing of constitutional value.¹³ The situation highlights a framework which pertains to a specific procedure or type of similar procedure. The procedure's significance isn't defined as a solution to medical deviations, but rather the reason for which it was adopted and the safeguards which accompany it.

4. Three decisions that require different safeguards

⁸ *Common Cause v Union of India* (2023) 14 SCC 131, modified directions 198.3.1-198.3.2.

⁹ *Common Cause v Union of India* (2023) 14 SCC 131, modified directions 198.4.3 and 198.4.5. The preferred period is not deemed permission to withdraw treatment automatically.

¹⁰ *Harish Rana v Union of India* 2026 INSC 222, paras 324 and 327(a).

¹¹ *Harish Rana v Union of India* 2026 INSC 222, para 327(c)-(d).

¹² *Harish Rana v Union of India* 2026 INSC 222, para 327(f).

¹³ Convention on the Rights of Persons with Disabilities 2006, arts 10, 12 and 25.

4.1 A competent patient's present refusal

A patient who can understand the essential information and communicate a voluntary choice occupies a different legal position from one whose wishes must be reconstructed. Constitutional privacy jurisprudence supports decisional autonomy and bodily integrity¹⁴, while Common Cause applies those commitments to treatment-related choices. Evaluation, therefore, must focus on the particular decision: does the patient understand the intervention, and its likely consequences and alternatives? No incapacity can be established due to disability, age or unpopular choice only.

A consent form does not exhaust information, but it is necessary¹⁵. Clinicians should differentiate between the physiologic effects of a treatment and what benefit it has for this patient. A refusal should be explored for fixable pressures such as a false belief that treatment or pain relief is unavailable. This not mean unlimited questioning until the patient accepts the clinician's choice. The aim of protection is to allow the party to make a free choice based on informed content.

4.2 An advance directive after loss of capacity

An advance directive ties present treatment to an earlier use of autonomy. The proof value relies on the genuineness, voluntary nature, applicability, and existence of a valid revocation¹⁶. Common Cause, on the other hand, draws attention to the clarity of the instructions and when they become operative. A directive should not serve as a blanket mandate to discontinue all future treatments, irrespective of unforeseen circumstances.

Interpretation gives rise to special difficulty. Without an understanding of the subsequently available, short-term intervention, a person may oppose continued dependence. A body may exaggerate vagueness to refrain from acting on clear orders. You sphere marked objects afforded a bygone yet excellent permanent mark. The designated representative of a patient should explain the directive based on known values¹⁷ but should not gain unlimited power to replace those values with their own or those of a financial nature.

4.3 No directive and no present capacity

A reliable instruction does not imply inventing consent for the task It aims to establish the best interests of the patient¹⁸ according to the law. Harish Rana investigates this question in detail considering the medical benefit, the situation of the patient, and the views of those closely involved in the care. The testimony of family members can throw light on the life of the person and their commitments. Just as the fact that the witnesses are relatives, does not make their testimony conclusive.

The most powerful best interests account combines a clinical assessment with respect for the patient's uniqueness. It asks what treatment might achieve, how burdens and benefits relate to that person, and whether a verdict is justified without having to state that dependent lives are inferior. In cases where there is a split in the family, the prognosis is disputed or there is material conflict on the part of a carer an independent review

¹⁴ *Justice K S Puttaswamy (Retd) v Union of India* (2017) 10 SCC 1; *Common Cause v Union of India* (2018) 5 SCC 1.

¹⁵ *Samira Kohli v Dr Prabha Manchanda* (2008) 2 SCC 1. Consent must be real, voluntary and adequately informed. The judgment does not make a signed form universally necessary for every medical interaction.

¹⁶ *Common Cause v Union of India* (2018) 5 SCC 1, paras 198-199, as modified in *Common Cause* (2023) 14 SCC 131.

¹⁷ *Common Cause v Union of India* (2018) 5 SCC 1, directions on the content, applicability and withdrawal of advance directives.

¹⁸ *Harish Rana v Union of India* 2026 INSC 222. See also the concurring opinion of K V Viswanathan J on the scope of best interests.

is critical¹⁹. A quick judicial channel should be kept open for such disputes without making litigation the necessary starting point in every case.

5. Ethical tensions beyond the autonomy–sanctity binary

5.1 Respect for life and the limits of intervention

The sanctity of life position warns against regularizing decisions to deliberately devalue vulnerable people's lives. If we go by autonomy-based reasoning, keeping a life going through unwanted intervention may instrumentalise the person. Indian doctrine tries to balance both concerns by differentiating between withdrawal of treatment in certain circumstances and intervening to kill²⁰. No single principle can answer every clinical question. Valuing life does not always mean every technically possible treatment must be used; respecting autonomy does not exclude being able to make a proper application.

A key difference in ethics is that of the object. The focus of an investigation should be the intervention, not the individual. An assessment that a treatment has “no relevant therapeutic benefit” must be supported by evidence; a judgment that a person's life is “not worth living”²¹ is one that falls outside the boundaries of equality guaranteed by the Constitution. The differentiation will also stop the language of dignity from turning into a standard imposed externally about independence, communication or productivity.

5.2 Vulnerability, relationships and economic pressure

Autonomy is practiced within relationships²². Families offer knowledge, help and emotional support, but may also suffer from fatigue or expense. We should recognize these situations without presuming that caregivers will coerce. The institution's response should differentiate between the treatment interest of the patient and the family's social and economic need. A lack of support that could have been avoided is reflected in the decisions, which are said to be voluntary.

The Convention on the Rights of Persons with Disabilities²³ establishes a link between equal recognition, protection of life and health access free of disability discrimination. When it comes to end-of-life decisions, these commitments suggest that we should be careful of assuming that having intensive support means that continued life is undesirable. No need to disregard a disabled person's valid refusal. When we respect someone as equal, we do not assume they are incapable of exercising their agency. We will scrutinise any negative judgement made on their behalf, not accepting it without question.

5.3 Palliative care is not abandonment

Discontinuing a certain intervention does not eliminate the obligation to provide care. Palliative care is a response to physical, psychosocial, and spiritual suffering, as defined by WHO²⁴, associated with illness that is potentially fatal. For this reason, it is relevant prior to a final life support decision. Availability of symptom relief and clear explanation of care options can improve the quality of the deliberation without predetermining the outcome.

¹⁹ *Common Cause v Union of India* (2023) 14 SCC 131; *Harish Rana v Union of India* 2026 INSC 222.

²⁰ *Gian Kaur v State of Punjab* (1996) 2 SCC 648; *Common Cause v Union of India* (2018) 5 SCC 1.

²¹ Convention on the Rights of Persons with Disabilities 2006, arts 10 and 25. The equality principle concerns the person's equal worth, not a requirement to impose every treatment.

²² Catriona Mackenzie and Natalie Stoljar (eds), *Relational Autonomy* (Oxford University Press 2000).

²³ Convention on the Rights of Persons with Disabilities 2006, arts 10, 12 and 25.

²⁴ World Health Organization, 'Palliative Care' (5 August 2020), WHO fact sheet.

The Harish Rana ruling clears the distinction between the withdrawal of treatment and withdrawal of care²⁵. Making a legally authorised decision does not free people from their professional responsibility for comfort, communication and dignity. The acceptance of 'it's OK, as the relatives accepted it' should not become their duty. The safeguard for a patient is an actual care plan which must include the responsible clinical team and, if circumstances change, arrangements for reassessment.

6. From legal permission to accountable clinical practice

Maintaining meaningful oversight without re-creating inaccessible bureaucracy is the key implementation question. A uniform decision record might define the patient's current capacity, the existence and validity of an advance directive²⁶, the clinical rationale for the proposed decision and any dispute. These are distinct evidentiary issues. Having them recorded separately will lessen the chance that family consent will come to be mistaken for clinical justification, or a prognosis taken to be evidence of the patient's wishes.

It is essential to integrate accessibility into the process itself. An ordinary language explanation, translation, assisted communication and a non-digital avenue to document instructions would ensure that legal formalities do not favour literate, urban or digitally-connected patients. The disability-rights framework mandates accessibility, reasonable accommodation²⁷ and more. Using another approach would make capacity assessment more credible. Communication difficulty should trigger support, not a conclusion that the person cannot decide.

To be truly independent, institutions require more than two differently named boards. Reviewers should disclose relevant conflicts, look at the evidence underlying a recommendation and give reasons against endorsing it. The Harish Rana district panels²⁸ provided an administrative starting point: the mere existence of a panel should not be confused with proof of independence in a particular case. Hospitals could keep a record of the dates when patients are referred, the decision and delay reason. Information like this would help in assessing without publishing patient insights.

Disagreement should compel a proportional action. The omission of minor documents, a dispute regarding prognosis, and the allegation of coercion will require different corrective measures. An impartial clinical assessment could clarify the first substantial uncertainty, credible coercion might necessitate protective measures, and an unresolved legal contention²⁹ could need a judicial resolution. With this graduated approach, access would remain but more scrutiny was directed to risky decisions.

²⁵ *Harish Rana v Union of India* 2026 INSC 222, paras 325 and 327(c)-(d).

²⁶ For the distinct decision-making pathways, see *Common Cause v Union of India* (2018) 5 SCC 1; *Common Cause v Union of India* (2023) 14 SCC 131.

²⁷ Rights of Persons with Disabilities Act 2016, ss 2(y), 3 and 25.

²⁸ *Harish Rana v Union of India* 2026 INSC 222, para 327(f).

²⁹ *Common Cause v Union of India* (2023) 14 SCC 131, modified directions concerning recourse to the High Court under art 226.

In *Harish Rana* case, the court stated absence of effective end-of-life legislation³⁰ and that judicial guidelines were interim. The observation from March 2026 identifies an institutional problem: the case-based directions necessarily respond to the disputes which reach court. A subsequent law or regulatory framework ought to be carefully assessed for how it defines “capacity”, how it protects the rights to refuse treatment, how it manages conflict, how it protects those clinicians acting in compliance with law, and how it assures access to care. These questions cannot be answered only by codifying some general phrase like “death with dignity”.

Another issue is the evidentiary weight of silence. When you don’t have an advance directive³¹, it cannot properly be assumed that you wish for every possible intervention, nor that you wish that treatment be withdrawn. People may never have come across the relevant information, may have assessed the question as remote, or may have been unable to fulfil the requisite formalities. None of these options indicate a strong preference. They elucidate why the evidentiary inquiry ought to remain open, rather than allowing the absence of a document to ultimately determine the clinical-ethical question.

Be careful with family arrangements as well. Consensus may lessen discord, but its constitutional significance depends on what the participants agree about. The acknowledgment that recovery is unlikely differs from agreement about the patient's values³², and both differ from the acknowledgment of the burdens of a particular intervention. This means we should clearly identify these propositions. This requirement would protect both clinicians and patients by making the rationale for the decision readily visible to subsequent reviews instead of forcing them to reconstruct it from a generic consent.

An important objection for increased documentation can be ascribed to two issues. For one, records may take up valuable clinical time. Second, documentation may replicate the formalism procedural simplification attempted to eliminate. The solution is not to gather every possible detail. A suitably proportionate record would capture the information required to determine the relevant decision-making pathway, the clinical justification, the ascertainable wishes of the patient and the care plan³³. The depth of inquiry should be enhanced when evidence is conflicting or there is a credible risk of coercion. This refers to a functional account of safeguards, where any additional procedure must be capable of being shown to have a protective purpose.

³⁰ *Harish Rana v Union of India* 2026 INSC 222, discussion preceding the operative directions. This is a description of the position addressed in that judgment, not verification of later legislative developments.

³¹ For the separate pathway applicable without an advance directive, see *Common Cause v Union of India* (2023) 14 SCC 131; *Harish Rana v Union of India* 2026 INSC 222.

³² For patient-centred best-interests reasoning, see *Harish Rana v Union of India* 2026 INSC 222.

³³ The proposed documentation framework draws on *Common Cause v Union of India* (2023) 14 SCC 131; *Harish Rana v Union of India* 2026 INSC 222.

Ultimately, the quantity of applications yielded a favorable or unfavorable outcome ought not to be regarded a measure constitutional success. Either figure could reflect appropriate individual choices, unavailable services, excessive caution, or inadequate checking. Aggregate counts cannot differentiate those explanations without examining the underlying records. An effective audit would instead question whether people received intelligible information, whether obligatory assessments were impartial³⁴, whether reasons addressed the proof and whether continuing care was actually organised.

7. Conclusion

Article 21 caters to a specific domain regulating treatment, consent and care rather than being understood as a general constitutional right to death. Gian Kaur, Common Cause and Harish Rana serve different doctrinal purposes, such as delineating the contours of the right, recognizing autonomy from treatment and procedural safeguards in a particular case. The combined meaning of these will be lost if each is interpreted as a mere unqualified approval for the euthanasia or its rejection.

The current challenge is to make the framework both credible and accessible. Competent refusal, advance directions and best-interests assessment require differentiated procedures. Equality requires the disability should not be devalued. Freedom from coercion is necessary for autonomy. Dignity requires attention even after the act ends. Thus, in the constitutional assessment of such an end-of-life system, what matters is not whether it readily allows or resists withdrawal, but whether it can justify each decision by reliable evidence, the patient's interests and a continuing commitment to decent care.

³⁴ *Harish Rana v Union of India* 2026 INSC 222, para 327. The suggested audit is the author's implementation proposal, not a finding that these safeguards operate uniformly.

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