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A MULTIDISCIPLINARY ANALYSIS OF PASSIVE EUTHANASIA IN INDIA FROM THE 2018 SUPREME COURT DIRECTIVE TO THE FIRST IMPLEMENTED CASE (2026)

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ABSTRACT
The recognition of the right to die with dignity represents a significant development in Indian constitutional and medical jurisprudence. The landmark decision in Common Cause (A Regd. Society) v. Union of India (2018) legalized passive euthanasia and recognized advance medical directives (living wills) as an extension of Article 21 of the Constitution. This study examines the legal, ethical, and policy evolution of passive euthanasia in India from early judicial debates to the first judicially implemented case in 2026. A qualitative doctrinal and comparative research methodology was employed, involving the analysis of constitutional judgments, legal documents, policy reports, and bioethical literature, alongside a comparison with end-of-life frameworks in selected international jurisdictions.
The findings indicate that India has developed a constitutionally grounded framework for passive euthanasia, strengthened by procedural reforms introduced in 2023. However, significant implementation challenges remain, including limited public awareness, inadequate palliative care infrastructure, lack of comprehensive legislation, and insufficient professional training. The 2026 decision in Harish Rana v. Union of India serves as a landmark practical application of the legal framework and highlights both its strengths and operational limitations. The study concludes that judicial recognition alone is insufficient to ensure meaningful realization of the right to die with dignity. Comprehensive legislation, expanded palliative care services, public education, and institutional capacity-building are essential for effective implementation and ethical end-of-life governance in India.
Keywords: Passive euthanasia, right to die with dignity, Article 21, advance medical directives, bioethics, palliative care, India.

1. INTRODUCTION

Around the world, how people die is often very different based on cultural beliefs and practices. Over the last few decades, with advances in medicine and an increase in the discussion of human rights, this topic has begun to raise significant questions. Who makes decisions on the proper course of end-of-life care? When should treatment be withheld or discontinued? These questions are not purely theoretical; rather, they have various legal, clinical and ethical consequences on the individual patient, the patient's family and/or healthcare providers and the overall healthcare system within a country.
In 2018, India, one of the largest democracies in the world, achieved a significant milestone by having a five-judge constitutional bench of the Supreme Court determine that an individual's right to die with dignity is encompassed within the right to life under Article 21 of the Constitution [1]. This decision not only gives legal formalities to passive euthanasia, but also creates an additional legal formalism for individuals who wish to make "living wills." Many bioethicists, advocates for patients' rights and healthcare workers viewed this development as a significant milestone in society. However, in practice, implementation of this policy has been difficult, beginning with diminished enthusiasm from supporters.
In 2023, five years later from previous, the Supreme Court reviewed again and simplified advance directive requirements. They removed magistrate attestation requirement; people can use notarization now. Things got really interesting when Supreme Court okayed the first case of passive euthanasia in India (Harish Rana v. Union of India, 2026 SCC OnLine SC 358) in March of 2026. This was a case where life support was removed from an individual who, following an accident in 2013, had been in a persistent vegetative state for thirteen (13) years.
This paper discusses changes made in how advance directives are regulated/determined through a variety of lenses including; analysis of constitutional law, exploration of bioethics, clinical examination of the documents from both patient and physician's perspective, and lastly how other countries approach this issue. The questions posed are; what has changed in the Indian legal framework between 1994 and 2026, what bioethical conflicts exist in the Indian model of euthanasia, how does the Indian model compare to other models in other countries, and what barriers exist to the effective application of the Indian legal framework? Also, what kind(s) of policy guidance are needed to ensure dignity for the dying in India?

2. HISTORICAL AND DOCTRINAL CONTEXT

2.1 Early Judicial Debates on the Right to Die

These questions about "right to die" under Article 21 had been posed to the Supreme Court of India as early as the early 1990s. The first case where it was ruled upon was P. Rathinam v. Union of India in 1994, where a two-judge constitutional bench of the Supreme Court indicated that the right to life included the right not to live and made attempts to commit suicide lawful. However, this ruling was short lived. In Gian Kaur v. State of Punjab in 1996, a five members constitutional bench of the Supreme Court of India overruled this proposition that Article 21 includes a right to die or assist another in dying, and very explicitly indicated that there is a substantive and real difference between a person who dies of natural causes and one who hastens his/her death through his/her own actions or through the actions of others.

The main feature of Gian Kaur was that it created a distinction between the "extinction of life" and "death with dignity." The judges recognized that although "extinction of life" was not encompassed within Article 21, a person could still die with dignity in terms of protection under Article 21. This minor distinction provided the basis for subsequent decisions on passive euthanasia, but concluded with a definitive "no" to active euthanasia as a constitutionally protected right.

2.2 The Aruna Shanbaug Case (2011)

In 2011, there was an important Supreme Court Case before the year 2018 called Aruna Ramchandra Shanbaug vs The Union of India. It involved a nurse who had been in a permanent vegetative state since 1973 after being attacked in Mumbai, and while the court ruled that they could not allow the removal of her support, they stated that in some cases "passive euthanasia" could be permissible. In order for this type of passive euthanasia to occur, it required the approval of the High Courts through their parens patriae powers, as well as consultation with medical boards. These procedures ultimately became more specific with the implementation of laws pertaining to passive euthanasia in 2018.

2.3 Legislative Gap and Growing Awareness (2011–2018)

India had not enacted any legal provisions regarding end of life decisions for the years 2011-2018. The Law Commission of India proposed that both passive euthanasia and living wills should be legalized in their reports of 2006 and 2012. However, there have not been any further developments relating to these recommendations [5, 26]. Due to the absence of legislation concerning end of life decisions, medical staff, family members and hospitals were uncertain as to what action should be taken. There was often therefore continued use of life support longer than people wished, resulting in frustration and cost to all concerned.

Table 1. Key Judicial and Legislative Milestones in the Evolution of Passive Euthanasia in India

Year	Case / Event	Key Holding / Development
1994	P. Rathinam v. Union of India	Two-judge bench: right to life includes right not to live; attempted suicide decriminalised
1996	Gian Kaur v. State of Punjab	Five-judge bench reverses 1994 ruling; distinguishes "dying with dignity" from right to die
2006	Law Commission 196th Report	Recommended legislation permitting passive euthanasia and living wills
2011	Aruna Shanbaug v. Union of India	Passive euthanasia permissible via High Court; procedural guidelines issued
2012	Law Commission 241st Report	Reaffirmed and expanded earlier recommendations on living wills
2018	Common Cause v. Union of India	Landmark: passive euthanasia legalised as constitutional right; advance medical directives recognised
2023	SC Modified Guidelines	Magistrate attestation replaced by notary/gazetted officer; High Court only for contested cases
2026	First Implemented Case	SC authorises withdrawal of life support for Harish Rana (32 years old, in PVS for 13 years)—first practical application; Harish Rana v. Union of India [27]

SC = Supreme Court; PVS = Persistent Vegetative State.

3. THE 2018 LANDMARK JUDGMENT: COMMON CAUSE v. UNION OF INDIA

3.1 Constitutional Bench and Arguments

In the Common Cause case, a group of registered individuals approached the Supreme Court and requested formal recognition of a right to die peacefully and to make advance medical directives [1]. Hence, a five-judge bench of constitutional law proceeded to consider these weighty issues. People were able to voice their opinions about this in terms of rights, medical ethics, religion and how it works in other countries. Initially, the Government of India was not fully in favor of legalising this because of the potential for misuse and the lack of strong guidelines on how the law could be used.

3.2 Key Holdings of the Court

1. Dying with dignity is included under Article 21 of the right to dignity. Therefore, if life support is against the wishes of terminally sick or vegetative patients or what they determined while they were competent, the state cannot compel them to get it [1].
2. Now, under some circumstances, passive euthanasia - that is, ceasing to provide life support - is acceptable. In order for this to occur, certain regulations must be adhered to and approval from the legal and medical communities is needed.
3. Furthermore, adults who are capable of making wise judgments are entitled to create advanced medical directives. These directives specify the type of care they desire in the event that they are unable to make decisions in the future. If all the necessary procedures are followed beforehand, they are lawful.
4. On the other hand, Indian law prohibits active euthanasia. It is considered a criminal offense. The Court distinguished between willfully causing someone is dying and allowing nature to take its course.

3.3 Procedural Framework Established

In 2018, a specific process was created to manage Living Wills. To be considered valid, a competent adult must evidence his/her intention / ability to sign the Living Will before two witnesses and have the Will counter-signed by the Judicial Magistrate of the First Class. Where the patient is unable to make his/her own decisions due to incapacity, and there is no Living Will, the attending physician must consult with two Medical Advisory Boards and ultimately seek approval from the High Court [1]. The long delays associated with this process were widely criticized as being excessively slow; obtaining approval from the High Court was viewed by some as taking several months alone.

4. LIVING WILLS AND ADVANCE MEDICAL DIRECTIVES IN INDIA

4.1 Conceptual Underpinnings

An advance medical directive (AMD) allows adults who are mentally competent to express their wishes concerning medical treatment if they ever lose the ability to make decisions in the future. The AMD is a legal document governed by the ethical principle of patient autonomy as expressed by Beauchamp and Childress, which consists of four principles of biomedical ethics: (1) autonomy, (2) beneficence, (3) non-maleficence, and (4) justice. Essentially, if you made informed decisions today, those decisions may impact your future medical care if you are unable to make those decisions at that time. However, in India, individual autonomy is not always respected by medical professionals because most decisions made about the care of patients are made collectively by family members. In the Indian context, this collective decision-making can result in a greater degree of authority given to family members or the collective than to the individual.

4.2 Content, Scope, and Limitations

In a legitimate Indian living will, the patient can decline ventilator assistance, artificial nourishment, CPR, designate a healthcare proxy, and specify conditions (terminal illness, persistent vegetative state, brain dead). It may not allow active euthanasia or care disengagement from competent patients. While competent, the executor might revoke it at any time.

Table 2. Requirements for a Valid Living Will in India: Pre- and Post-2023 Reforms

Requirement	Pre-2023 (2018 Guidelines)	Post-2023 (Simplified)
Executor eligibility	Adult (≥18 yrs), sound mind	Adult (≥18 yrs), sound mind
Written document	Mandatory	Mandatory
Witnesses	Two; not family members	Two; not family members
Attestation	Judicial Magistrate (First Class)	Notary Public or Gazetted Officer
Medical board review	Two independent boards required	Two independent boards required
Final authorisation	High Court bench approval	Hospital notifies Magistrate; court only for contested cases
Healthcare proxy	Permitted	Permitted
Revocability	Any time by executor	Any time by executor
Language	No explicit requirement	Regional languages officially recognised

Source: Common Cause v. Union of India [1]; SC Modified Guidelines (2023) [8].

5. THE 2023 PROCEDURAL REFORMS

Although this ruling occurred in 2018, implementation was lacking mostly due to legal/medical bureaucracy. Medical professionals, lawyers and hospital administrators cited laws that required the use of a magistrate and/or high court permission, as significant hurdles to implementation during urgent events [8]. A petition from 2022 confirms this when it states that there have been no valid instances of any form of advanced care directive as defined by the legislation in 2018.

In response to the above obstacles, the Supreme Court released revised procedural guidelines in 2023 [8]. These new rules removed the requirement for a magistrate's signature; notary public or gazetted officer will now suffice. The only instance where high court approval is required will be when there is a dispute. Additionally, all large facilities with ICUs or emergency rooms that treat critical patients are now required to have established ethics

committees. Finally, advanced medical directives will no longer have to be written in English; they can now be written in any Indian language.

While these reforms increased access to advanced care directives, there are still several structural issues that remain. The continuing requirement of two signatures causes additional delays. There still is no existing federal registry for advanced care directives. There has been no change in the educational system for physicians or anyone else that would involve the new laws and the parliament has not yet passed any new laws; therefore, the framework in creating and carrying out advanced care directives relies solely on judicial order.

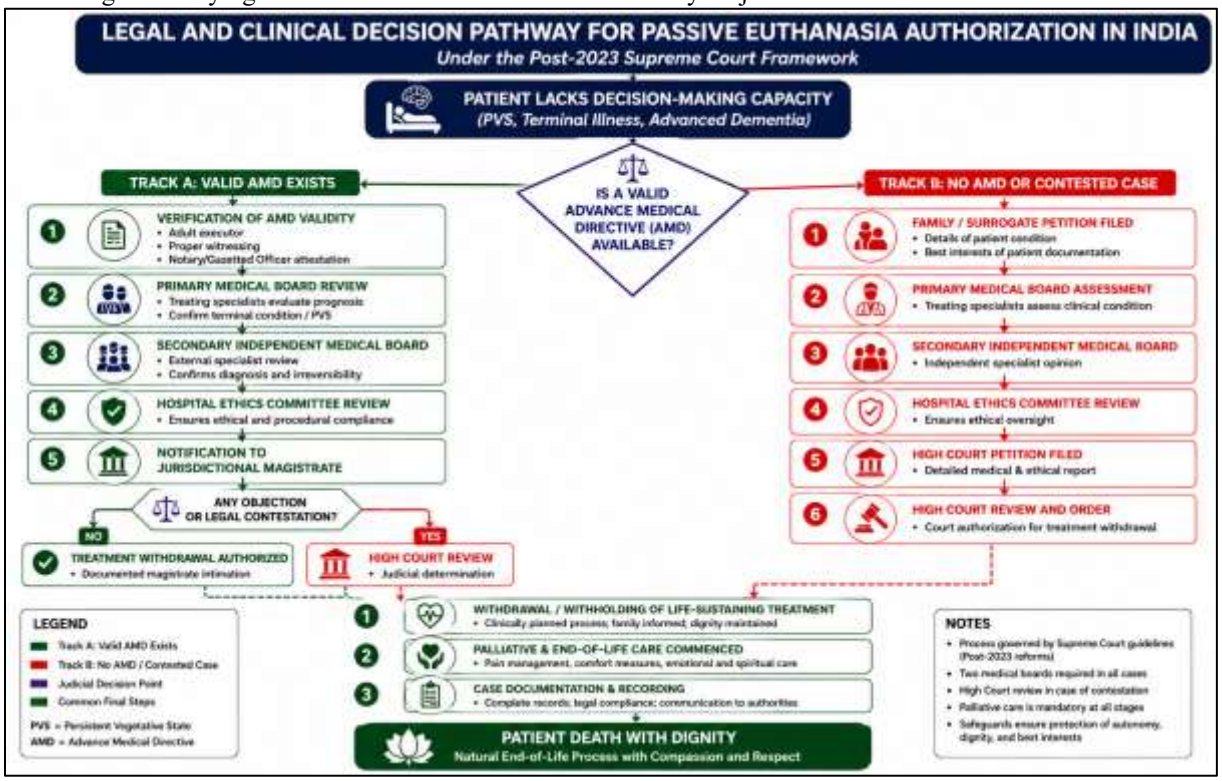


Figure 1. Passive Euthanasia Authorization Procedure in India (Post-2023 Reforms). Track A applies when a valid advance medical directive exists; Track B applies when no directive exists or the case is contested. AMD = Advance Medical Directive.

6. INDIA'S FIRST IMPLEMENTED CASE OF PASSIVE EUTHANASIA (MARCH 2026)

6.1 Case History

On March 23, 2026, the Supreme Court of India made a ruling allowing doctors to withdraw all life-sustaining treatment provided to Harish Rana, who had been in a persistent vegetative state since his injury on June 12, 2013 (after falling from a fourth-floor balcony and experiencing severe brain damage). As a result of his injury and the fact that he would never regain consciousness or independence, he has required assistance with breathing, eating, and drinking. Since Mr. Rana did not expect to have such a serious injury and had not previously put any plan in place, the court intervened to allow Mr. Rana's family to withdraw their support and allow doctors to provide appropriate care, at the request of the family, following an assessment of the case by medical experts.

6.2 Legal Procedures and Rationale

Two independent medical experts from the state and the hospital agreed that Mr. Rana would not return to consciousness; therefore, he met the clinical criteria for a Persistent Vegetative State (PVS), and the recommendation to withdraw life-sustaining treatment was in keeping with the family's prior expressed wishes regarding end-of-life care, as evidenced by testimony provided by the family. The case was originally filed in the Delhi High Court, but it was later decided by Judges J.B. Pardiwala and K.V. Viswanathan after receiving evidence from the medical experts and listening to testimony from the family, as well as a neutral attorney. Following consideration of the testimony of the medical experts and of Mr. Rana, the Supreme Court approved Mr. Rana's request to withdraw life support and ordered the medical provider to provide a palliative care plan and support for the family until the end.

6.3 Significance and Lessons

There are multiple ways this case is significant. From a legal perspective, this is the first time India has applied their passive euthanasia laws since they were established approximately eight years ago. Additionally, this case demonstrates how well the system of two boards and a judicial review function; however, it further demonstrates that this system is not sustainable in the longer term given the sheer volume of patients in ICUs throughout the year. Finally, there has been a tremendous increase in requests for living wills by legal organizations, as they report many more inquiries since last month's ruling.

7. COMPARATIVE INTERNATIONAL ANALYSIS

7.1 Netherlands and Belgium

In 2002, The Netherlands signed the Termination of Life on Request and Assisted Suicide Act (or, the "Act"), an important piece of law which permits both active euthanasia and assisted suicide by a physician for patients who meet certain strict "due care" criteria (9). The latest statistics from the Regional Euthanasia Review Committees show that there is a continuing increase in the use of Euthanasia in the Netherlands; for example, now there are more than 9,000 cases a year (as of 2023), compared to less than 2,000 each year in the first few years after Euthanasia was legalized. Many of the patients who received Euthanasia were diagnosed with cancer. Belgium adopted a very similar law in 2002, and was one of the first countries to allow minors who are terminally ill to have Euthanasia beginning in 2014. What this demonstrates from The Netherlands is that with the right level of oversight, there can be limited issues with the practice of Active Euthanasia. However, India has a much more restrictive approach to euthanasia, allowing only passive forms of euthanasia through the legal system; although the same can be said about the degree to which India believes in a patient's right to make choices regarding their own care, their system of independent physician reviews is as rigorous as that of the Netherlands [10].

7.2 United States

Each state in the US establishes their own laws in regards to the end of one's life. However, life support can legally be taken away in all fifty states because of the Patient Self-Determination Act which was written in 1990 and the advance directive laws within each state. Approximately one-third of adults in the US have completed an advance directive [12]. In addition to this, there are 13 states and Washington D.C. that permit physician-assisted suicide (referred to as “death with dignity”) where there are strict restrictions on eligibility from a medical standpoint, or from the documentation standpoint as well (two requests are needed to deny death).

There is much that India can learn from the US about establishing hospital ethics boards and how to create surrogate decision makers for patients. Finally, relationship between the planning of end-of-life care and how to provide palliative care is also important.

7.3 United Kingdom

The UK has the Mental Capacity Act (2005) provide guidance on how to make decisions about when to withdraw life support from patients, and this act emphasize that decisions made should be in the best interest of the patient. The issues of active euthanasia and assisted dying have not yet been codified into law but are becoming more frequent topics of discussion in Parliament [14]. The National Health System (NHS) publishes detailed clinical guidelines to assist providers when completing advance planning, and establishing Lasting Power of Attorney, for their patients. As India is developing its Primary Health Care (PHC) system, India can learn from how end of life (EoL) decision making is incorporated into routine clinical practice in the UK.

7.4 Canada

In 2016, Canada legalized MAiD (medical assistance in dying), which was based on the Supreme Court of Canada decision that ruled in Carter v. Canada (2015) that MAiD was unconstitutional. The Ontario M.A.I.D. program is reported to be functioning within established safety parameters and providing relief for qualified individuals according to early evaluation studies [15]. Canada’s process of developing and refining its existing laws regarding EoL decisions could provide valuable information for India as it develops its own process.

Table 3. Comparative International Framework for End-of-Life Decisions.

Country	Passive Euthanasia	Active Euthanasia	Physician-Assisted Dying	Advance Directives	Governing Instrument
India	Legal (2018)	Illegal	Illegal	Legal (2018)	Supreme Court Directive
Netherlands	Legal	Legal	Legal	Legal	Termination of Life Act 2002
Belgium	Legal	Legal	Legal	Legal	Euthanasia Act 2002
USA	Legal	Illegal	Legal (13 states + D.C.)	Legal (PSDA)	State-level legislation
United Kingdom	Legal	Illegal	Illegal	Legal (MCA)	Mental Capacity Act 2005
Canada	Legal	Legal (MAID)	Legal (MAID)	Legal	Federal legislation (2016)
Australia	Legal	Illegal (most)	Legal (some states)	Legal	State-level legislation

MAID = Medical Assistance in Dying; PSDA = Patient Self-Determination Act; MCA = Mental Capacity Act.

8. ETHICAL DIMENSIONS

8.1 Autonomy and Self-Determination

Independent autonomy is one of the main ethical arguments for passive euthanasia as it embodies a person's autonomy in making decisions for their own body and for their own healthcare without intervention from others,

according to Beauchamp and Childress, to be autonomous is to make choices on purpose, with reflection, and not through coercive pressures [6]. The Supreme Court stated in 2018 that passive euthanasia falls under the concept of constitutional autonomy and therefore does not conflict with a person's rights. The Court's opinion states that forcing a terminally ill patient to receive unwanted medical care is degrading and a violation of their individual rights. This philosophy is supported by well-known bioethicists such as Keown and Singer [16, 17].

8.2 Beneficence, Non-Maleficence, and Futility of Treatment

There is a significant disparity between the principles of beneficence and non-maleficence through passive euthanasia. Physicians are trained to save lives; therefore, withdrawing treatment may create difficulty for a physician when they are conflicted about their ethical duty to continue saving lives. However, palliative care experts have expressed the opinion that if an individual does not have a medically sound chance of recovery, then keeping someone on active treatment only causes additional suffering and offers no value to the individual [6]. The notion of "futility" of treatment has gained more progressiveness within the society of India and forms the basis for several of the ethical decisions that are subsequently made, such as in the case of 2026**.**

8.3 Cultural, Religious, and Pluralist Issues

India's diversity makes it challenging to create a unified approach. According to some, many of the traditions within Hinduism maintain that there must not be any intervention in someone dying naturally and that passive euthanasia is one means that can achieve that goal [18]. Also, within Islam, Christianity and Sikhism, the various sects have widely different beliefs. To acknowledge the challenges and sensitivities of this issue, the Supreme Court (2018) chose to not consider the aspect of religion, but rather based their decision on constitutional grounds forbidding families from using their religious beliefs for their respective deaths [1].

8.4 Doom and Vulnerability

For many, one of the biggest concerns related to the decriminalization of passive euthanasia is that it may, as a result of this practice, give vulnerable individuals (e.g., elderly and/or the economically disadvantaged) pressure to die [16]. Many point to the "slippery slope" of this issue as a means to validate their concerns; however, the evidence cited from the Netherlands indicates that there have not been any significant problems since the practice was legalized [10]. In India, due to an inequitable distribution of health care, the issue is much closer to home, as is the issue of independent judgment on the boards that will be reviewing requests for passive euthanasia. Therefore, the presence of two independent boards and the court system may not prove to be a sufficient safeguard against applying undue pressure on individuals requesting to receive passive euthanasia.

9. CHALLENGES AND IMPLEMENTATION GAPS

9.1 Public Awareness

Awareness of passive euthanasia and advance medical directives remains very low across the country due to a lack of media coverage, neither government has developed programs to create awareness; language and literacy barriers throughout the diverse linguistic community are significant obstacles to communication. As such, around 15% of urban adults and approximately 5% of rural adults in 2018 were aware of their legal right to make an advance medical directive (living will) as of August 2020. By comparison, South India/Urban Kerala has a higher level of awareness (ranging 20-22%); however, it remains an exception to the national trend.

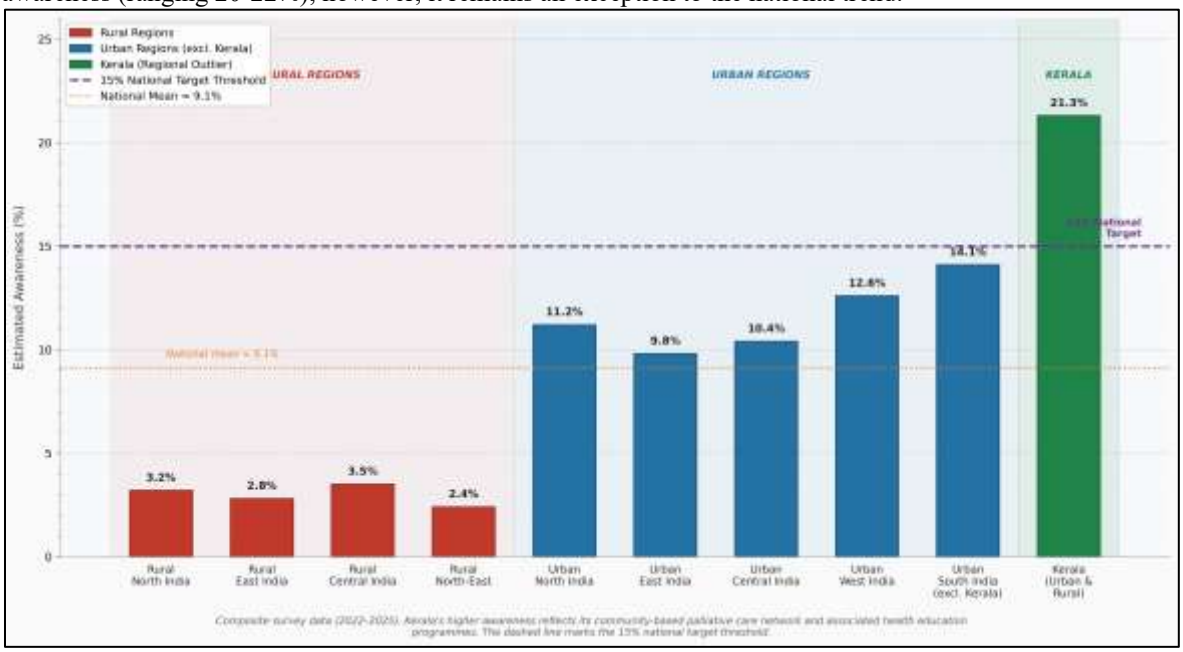


Figure 2. Estimated Awareness of the Right to Execute a Living Will Among Indian Adults by Region (Composite Survey Data, 2022–2025). Kerala's higher awareness reflects its community-based palliative care network and associated health education programmes. The dashed line marks the 15% national target threshold.

9.2 Infrastructure for Palliative Care

There is very little infrastructure available in India for providing palliative care services to those patients who require them. Approximately 5.5-7 million individuals in India require palliative care services each year, yet only about 4% actually receive effective assistance from the palliative care system in India [20]. The only state-level programme in India that provides effective palliative care is in Kerala; throughout most of India very little training exists on how to properly manage suffering related to pain and symptom control [21]. This lack of palliative care availability is relevant to passive euthanasia, because when considering whether or not it is appropriate to withdraw treatment at the end-of-life the question comes down to whether quality palliative care will be provided through the palliative care system or not; if it will not be possible to provide quality palliative care through the palliative care system, then withdrawing treatment at the end-of-life will likely be viewed as giving up on a patient rather than providing them with compassionate assistance.

9.3 Medical Community Attitudes and Training

A recent survey shows that although a number of Indian doctors, especially those who work in fields such as intensive care medicine or oncology, may agree with the concept of providing patients with dignity at the end of life, they do not seem comfortable stopping treatment for a dying patient and are not entirely sure of what the law protects them from [19]. The Indian Medical Association supports the Supreme Court's decision but believes that the current legal protections for physicians stopping treatment need to be clarified [22]. Additionally, medical schools in India do not incorporate enough education on the ethical considerations surrounding end-of-life issues into their pre- or post-graduate curriculums. Furthermore, very little instruction is presently available regarding advanced health care directives and legal considerations related to passive euthanasia in either pre-or post-graduate programs in India.

9.4 Legislative Silence

There's still the problem of a lack of legislation around euthanasia. India hasn't managed to enact a proper law about either passive euthanasia or about advance medical directives to date (2026) despite two Law Commission Reports to this effect and several Supreme Court ruling on the subject advising Parliament to take action. In relation to mental health, the Mental Healthcare Act 2017 provides for advance directives, but no equivalent exists for end-of-life, so doctors and hospitals continue to rely on case law or court guidance rather than to use the appropriate, established statutes to guide their practice. This creates confusion and eliminates the necessary legal framework which hospitals and/or physicians require to provide quality medical services.

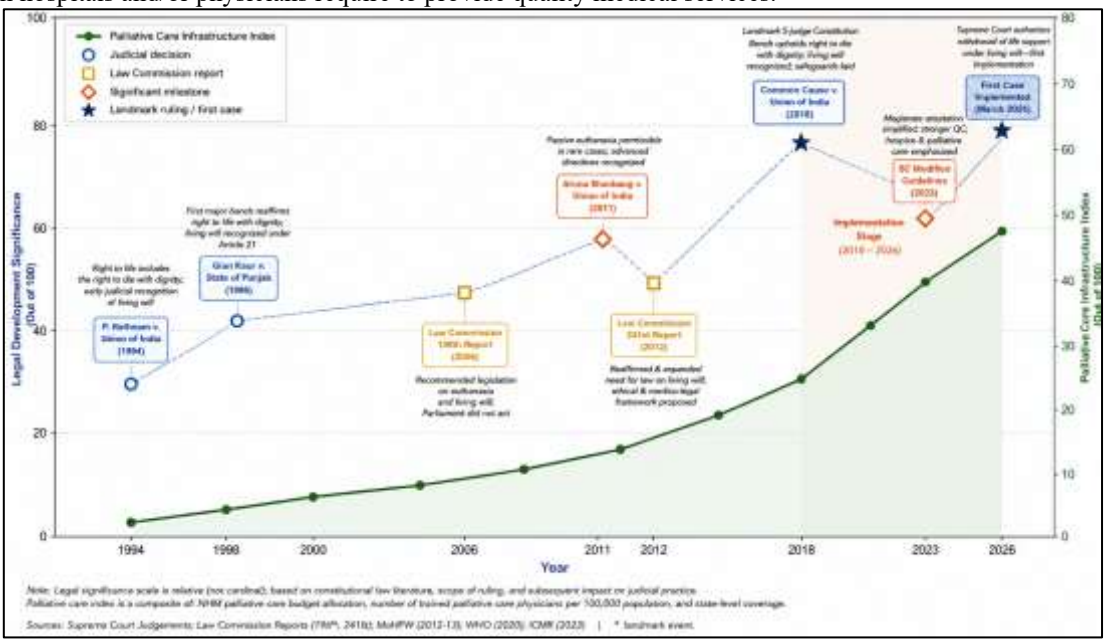
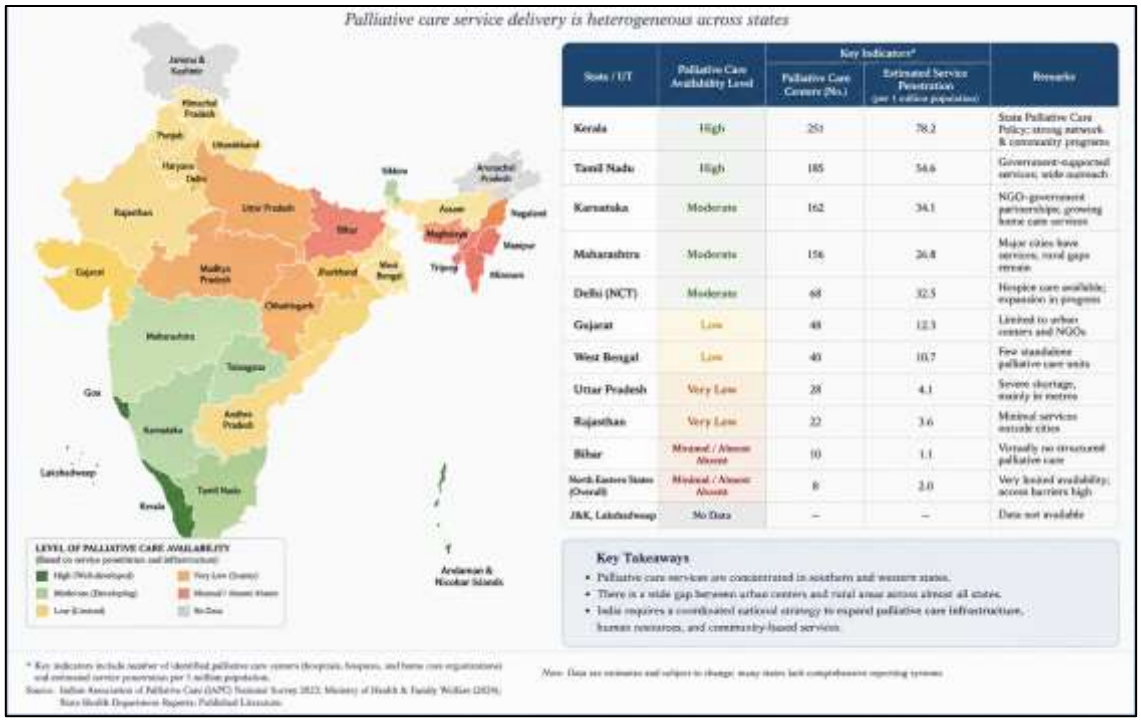


Figure 3. Legal Milestones and Palliative Care Infrastructure Development in India (1994-2026)



State / UT	Palliative Care Availability Level	Key Indicators*		Remarks
		Palliative Care Centers (No.)	Estimated Service Penetration (per 1 million population)	
Kerala	High	251	78.2	State Palliative Care Policy; strong network & community programs
Tamil Nadu	High	185	54.6	Government-supported services; wide outreach
Karnataka	Moderate	162	34.1	NGO-government partnerships; growing home care services
Maharashtra	Moderate	156	26.8	Major cities have services; rural gaps remain
Delhi (NCT)	Moderate	68	32.5	Hospice care available; expansion in progress
Gujarat	Low	48	12.3	Limited to urban centers and NGOs
West Bengal	Low	40	10.7	Few standalone palliative care units
Uttar Pradesh	Very Low	28	4.1	Severe shortage, mainly in metros
Rajasthan	Very Low	22	3.6	Minimal services outside cities
Bihar	Minimal / Almost Absent	10	1.1	Virtually no structured palliative care
North Eastern States (Overall)	Minimal / Almost Absent	8	2.0	Very limited availability; access barriers high
J&K, Lakshadweep	No Data	–	–	Data not available

Figure 4. State-Wise Availability of Palliative Care Services in India (2024)

10. DISCUSSION AND POLICY RECOMMENDATIONS

10.1 Synthesis of Findings

The passive euthanasia journey within India indicates the leadership role the Supreme Court of India has taken on where legislation has fallen behind; they have constructed an intricate constitutional basis in the last thirty years providing for how persons may die with dignity. The 2018 ruling by the Supreme Court in the case of Common Cause vs. Union of India is arguably one of the most significant constitutional cases in Indian legal history. Similarly, the example set by the case of Harish Rana 2026 demonstrates that, while the system is functional, it is still not particularly stable [27]. Countries that have legal frameworks and functioning palliative care systems provide a higher degree of support [9, 12, 15]. Therefore, there is an urgent necessity that Indian Parliament passes actual legislation.

10.2 Policy Recommendations

5. Pass Comprehensive Laws. A specific law on advance medical directives and passive euthanasia should be passed by Parliament, combining Supreme Court rulings into a framework that is legally binding. A national AMD registry, standardized language directive forms, unambiguous liability safeguards for doctors operating in good faith, and a specific oversight mechanism should all be included [23].
6. Include palliative care in universal health coverage. Palliative treatment in district hospitals and community health centers should be required and funded by Ayushman Bharat and state health programs. The Kerala model ought to be modified and expanded across the country [20, 21].
7. Restructure medical education. The legal framework for passive euthanasia and end-of-life care ethics should be required as fundamental competences in undergraduate and graduate programs by medical councils. Clinical training should incorporate simulation-based training for challenging treatment-withdrawal conversations [22].
8. Start a national campaign to raise public awareness. The National Legal Services Authority and the Ministry of Health should work together to launch a multilingual living will campaign that is distributed through conventional and digital media. At the primary care level, community health workers should be trained to describe the AMD process [19].
9. Create a National Monitoring Organization. To enable evidence-based policy modification, a specialized oversight body should gather, evaluate, and publish anonymized data on incidents of passive euthanasia and the use of AMD, reporting to Parliament on a regular basis.

11. CONCLUSION

In line with the worldwide trend toward patient-focused consideration of end-of-life options based-on autonomy and dignity is represented in the trajectory of passive euthanasia law in India. India's legal processes regarding the right to die have progressed considerably in the last thirty years: from the highly publicized P. Rathinam Case (1994) to the lengthy legal history of the Aruna Shanbaug Case (2011), to the Constitutional decision in Common Cause (2018), to procedural advances in 2023, to the first actual case of Harish Rana v. Union of India decided March 2026.

Despite these important advancements, there remains a large void between the existing experience of millions of Indians making decisions about end-of-life options, due to terminal illness, in the absence of any meaningful access to the rights conceded to them by the Supreme Court. The Harish Rana case should not be thought of as an end point but should be seen as a demonstration of what needs to happen in order to effectuate systemic change so that the process can be duplicated in the future.

Three elements will be needed for us to make any progress on helping people die with dignity. To this end, we need to improve how we talk about and discuss dying and death in our country given the complexity and diversity; improve the infrastructure and clinical capability of palliative care; and to ensure that legal protection is given for the right to die with dignity that has been established through the courts in this country. The right to die with dignity is not simply about ending a life in despair; it is about honoring the life that was lived. The right to die with dignity cannot just be a privilege for a few; it must be a right for all people for it to have meaning.

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