The Supreme Court has crafted a nuanced jurisprudence on passive euthanasia. Parliament must now act, set up accessible procedures and define institutional responsibilities to embed safeguards

INSTITUTING THE RIGHT TO DIGNIFIED EXIT

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ON March 11, the Supreme Court addressed one of the most difficult questions of life and death: whether, when and on what legal basis medical treatment may be withdrawn or withheld. In the *Harish Rana* case, it framed the issue not as whether it is in the patient's best interests to die, but whether it is in his best interests to prolong life with artificial support. This reframing shifted the debate from the morality of death to the legitimacy of prolonging life in conditions where dignity has irreversibly ebbed away.

The case arose from Rana, a 32-year-old man who remained in a persistent vegetative state (PVS) for over 12 years following a fall from his balcony. He was sustained on clinically-assisted nutrition and hydration (CANH) administered through a tube, with negligible prospects of recovery. It was a hard case at the intersection of law, medicine and ethics.

The court situated the issue within the constitutional framework developed in *Common Cause* (2018), where it held that the right to life under Article 21 includes the right to live with dignity, and therefore the right to reject an undignified existence. It recognised passive euthanasia by withdrawal of medical treatment and permitted individuals to execute advance medical directives, or living wills, specifying when life-sustaining treatment should not be continued.

Acknowledging a legislative vacuum, the court invoked Article 142 to lay down interim procedures governing withdrawal of life support, while expressing a "pious hope" that Parliament would enact a comprehensive law on end-of-life decisions. In 2023, the court streamlined these guidelines to address implementation challenges.

While Parliament is yet to act, the issue resurfaced in *Harish Rana*. His parents, after years of caregiving and unsuccessful attempts to secure relief from hospitals, approached the Delhi High Court, which declined permission to withdraw CANH on the ground that it did not constitute 'medical treatment'. A special leave petition before the Supreme Court also failed.

The family reframed the issue in a subsequent application, seeking the constitution of medical boards and a declaration that CANH is 'medical treatment'. This reframing proved decisive: successive medical boards the court convened confirmed that Rana was in a vegetative state with no realistic prospect of recovery and engaged directly with doctors, family members and counsel. It held that CANH is 'medical treatment' and that its withdrawal is in the patient's best interests. This clarification removes the ambiguity between 'care' and 'treatment' that could otherwise render the right to a dignified exit illusory.

The court reaffirmed the governing framework for discontinuing life support and applied it to the case. It emphasised that withdrawing or withholding treatment does not extinguish the patient's right to care; it marks a transition from curative intervention to a structured, medically-supervised palliative and end-of-life care plan.

The judgement reinforces the dual pathways envisaged in *Common Cause*. First, where an individual—while in a sound and conscious state—executes a living will, specifying in advance the circumstances in which treatment should be withheld or withdrawn, and authorises a representative to act on his behalf if he loses decision-making capacity. This is an expression of autonomy, an extension of personal liberty into the realm of end-of-life decisions.

Second, where no such directive exists, decisions to withdraw or withhold treatment must be made in the patient's best interests through a structured process involving medical boards, institutional oversight and procedural safeguards. This ensures that the absence of prior choice does not lead to arbitrariness.

Recognising the persistent implementation challenges, the court directed authorities to streamline the creation, preservation and retrieval of living wills, and to ensure the timely constitution of medical boards. These directions address longstanding attitudinal and logistical barriers that have limited the practical utility of living wills.

However, the judgement has a limitation: a patient in a vegetative state may lack the financial means to sustain prolonged artificial life support. This risks decisions ostensibly based on the patient's best interests may, in fact, be driven by economic compulsion, blurring the line between principled choice and financial exhaustion.

Earlier, the court directed that Rana be transferred to a government hospital to ensure continued care. It is, however, doubtful whether public hospitals can sustain such long-term care at scale. This gap is likely to widen. Advances in medical science prolong biological life. Simultaneously, demographic trends indicate a rapidly ageing population with a growing incidence of chronic and degenerative conditions. It results in an increasing number of patients requiring prolonged palliative care, intensifying the ethical and policy questions around dignity, autonomy and resources.

Through *Common Cause* and *Harish Rana*, the Supreme Court has crafted a nuanced and workable jurisprudence. It has moved from recognising a right in principle to making it operational in practice. But courts decide cases; they do not design systems. Without a law, families like that of Rana must still navigate uncertainty, often turning to courts for decisions that should be part of a structured and humane system.

A statute can do what judicial guidelines cannot. It can establish clear and accessible procedures; define institutional responsibilities; embed safeguards against misuse and integrate medical, legal and ethical standards into a coherent framework. It can also address systemic needs such as public awareness, professional training and the creation of efficient living will registries.

Jurisdictions such as the Netherlands, Belgium, Canada and Spain have enacted detailed laws governing end-of-life decisions, with varying approaches to eligibility, safeguards and oversight. While India need not replicate these models, they underscore the importance of legislative engagement with this complex domain.

The stakes are very high. A law on end-of-life decision-making must recognise that while life is sacred, dignity is inseparable from it. It must respect individual autonomy while protecting the vulnerable and enabling choice without misuse. Above all, it must ensure that no person is compelled to endure a prolonged, undignified existence merely because the system lacks clarity.

The Constitution has been interpreted. The right has been recognised. The framework has been laid down. It is now for Parliament to complete the task.

(Views are personal)