



INTERNATIONAL LAW  
JOURNAL

---

**WHITE BLACK  
LEGAL LAW  
JOURNAL  
ISSN: 2581-  
8503**

*Peer - Reviewed & Refereed Journal*

The Law Journal strives to provide a platform for discussion of International as well as National Developments in the Field of Law.

[WWW.WHITEBLACKLEGAL.CO.IN](http://WWW.WHITEBLACKLEGAL.CO.IN)

## DISCLAIMER

No part of this publication may be reproduced, stored, transmitted, translated, or distributed in any form or by any means—whether electronic, mechanical, photocopying, recording, scanning, or otherwise—without the prior written permission of the Editor-in-Chief of *White Black Legal – The Law Journal*.

All copyrights in the articles published in this journal vest with *White Black Legal – The Law Journal*, unless otherwise expressly stated. Authors are solely responsible for the originality, authenticity, accuracy, and legality of the content submitted and published.

The views, opinions, interpretations, and conclusions expressed in the articles are exclusively those of the respective authors. They do not represent or reflect the views of the Editorial Board, Editors, Reviewers, Advisors, Publisher, or Management of *White Black Legal*.

While reasonable efforts are made to ensure academic quality and accuracy through editorial and peer-review processes, *White Black Legal* makes no representations or warranties, express or implied, regarding the completeness, accuracy, reliability, or suitability of the content published. The journal shall not be liable for any errors, omissions, inaccuracies, or consequences arising from the use, interpretation, or reliance upon the information contained in this publication.

The content published in this journal is intended solely for academic and informational purposes and shall not be construed as legal advice, professional advice, or legal opinion. *White Black Legal* expressly disclaims all liability for any loss, damage, claim, or legal consequence arising directly or indirectly from the use of any material published herein.

## ABOUT WHITE BLACK LEGAL

*White Black Legal – The Law Journal* is an open-access, peer-reviewed, and refereed legal journal established to provide a scholarly platform for the examination and discussion of contemporary legal issues. The journal is dedicated to encouraging rigorous legal research, critical analysis, and informed academic discourse across diverse fields of law.

The journal invites contributions from law students, researchers, academicians, legal practitioners, and policy scholars. By facilitating engagement between emerging scholars and experienced legal professionals, *White Black Legal* seeks to bridge theoretical legal research with practical, institutional, and societal perspectives.

In a rapidly evolving social, economic, and technological environment, the journal endeavours to examine the changing role of law and its impact on governance, justice systems, and society. *White Black Legal* remains committed to academic integrity, ethical research practices, and the dissemination of accessible legal scholarship to a global readership.

## AIM & SCOPE

The aim of *White Black Legal – The Law Journal* is to promote excellence in legal research and to provide a credible academic forum for the analysis, discussion, and advancement of contemporary legal issues. The journal encourages original, analytical, and well-researched contributions that add substantive value to legal scholarship.

The journal publishes scholarly works examining doctrinal, theoretical, empirical, and interdisciplinary perspectives of law. Submissions are welcomed from academicians, legal professionals, researchers, scholars, and students who demonstrate intellectual rigour, analytical clarity, and relevance to current legal and policy developments.

The scope of the journal includes, but is not limited to:

- Constitutional and Administrative Law
- Criminal Law and Criminal Justice
- Corporate, Commercial, and Business Laws
- Intellectual Property and Technology Law
- International Law and Human Rights
- Environmental and Sustainable Development Law
- Cyber Law, Artificial Intelligence, and Emerging Technologies
- Family Law, Labour Law, and Social Justice Studies

The journal accepts original research articles, case comments, legislative and policy analyses, book reviews, and interdisciplinary studies addressing legal issues at national and international levels. All submissions are subject to a rigorous double-blind peer-review process to ensure academic quality, originality, and relevance.

Through its publications, *White Black Legal – The Law Journal* seeks to foster critical legal thinking and contribute to the development of law as an instrument of justice, governance, and social progress, while expressly disclaiming responsibility for the application or misuse of published content.

# **THE HARISH RANA LEGACY: BRIDGING THE GAP BETWEEN JUDICIAL GUIDELINES AND BEDSIDE REALITIES**

AUTHORED BY - DR SATISH CHANDRA & ARVIND RAWAL

## **ABSTRACT**

The decision made by the Supreme Court in the case of Harish Rana v. UOI has been a landmark case regarding India's legal framework with respect to end-of-life care. This was a case involving an individual who was suffering from Prolonged Permanent Vegetative State (PVS) and relied on Clinically Assisted Nutrition and Hydration (CANH). In the light of previous landmark cases on the same subject, the Supreme Court has reaffirmed that passive euthanasia remains legal provided it satisfies the required criteria and also stated that CANH is also included within the ambit of medical treatment. Thus, this judgment makes a move towards operationalising constitutional rights.

The research paper discusses the issue of the widening gap between what has been laid down through judicial guidelines for end-of-life situations and how these guidelines are implemented at the bedside. Even with the various measures that have been put in place regarding medical boards, judicial interventions, etc., there still remains uncertainty and reluctance among health-care institutions in making end-of-life decisions. Instead, the continuation of life-sustaining treatment is pursued in such cases owing not to the requirement of clinical care but rather because of the fear of legal implications in the absence of a proper palliative system. The decision in the Harish Rana judgment thus helps to highlight the weaknesses of the existing framework and demonstrates how difficult it is to implement fundamental rights in the realm of health care.

In general, this research asserts that the contribution made by the Harish Rana judgment consists of uncovering the problems inherent in implementing constitutional rights within the clinical context. Even though the Supreme Court reaffirms the concept of the best interest principle and highlights such aspects as dignity, autonomy, and humane attitude toward patients, the lack of adequate infrastructure for providing palliative care, ignorance of advance directives, and insufficient support systems remain the major barriers. Thus, the study suggests

that in addition to doctrinal clarity provided by the judiciary, legislative reforms and improvements in the functioning of health care facilities should be undertaken in order to achieve consistency between the theoretical concepts and practical realities.

## INTRODUCTION

The issue of interaction between law and death has remained an awkward interface between constitutional ethics, medicine, and human frailty from its inception. In the Indian context, such a contradiction has come out most glaringly through the changing interpretation of “the right to die with dignity” under Article 21 of the Constitution.<sup>1</sup> Although Court has consistently acknowledged that life as per Article 21 cannot be viewed as just biological existence but life of dignity, its implementation within clinical practice has continued to pose several challenges. In this context, the Supreme Court's decision in *Harish Rana v. UOI*<sup>2</sup> stands out as a crucial step toward implementing these ideas within clinical practice.

The *Harish Rana* case is particularly noteworthy since it is the first instance wherein the principles were put into practice in a long-term real-life situation involving a patient in a PVS maintained via CANH. With the acknowledgement that CANH constitutes medical care and that CANH can be discontinued provided certain precautions are taken by the courts, the Court went from endorsing passive euthanasia to implementing these ideas in clinical situations. Indeed, this step was a breakthrough since it involved engaging with the issues surrounding the use of life-maintaining technology in intensive care units and even homes where patients continue to live for years in unconscious states with no hope of ever regaining their senses.

In addition, the decision demonstrates the ongoing discrepancy between legally established mechanisms and their practical application in the field of medicine. On the one hand, the Court reinforces the procedural guarantees by implementing them via medical councils, judicial review, and recommendations concerning palliative care; however, on the other hand, the successful operation of these mechanisms depends on the capacity and medical literacy of the relevant institutions. In fact, in numerous instances, the relatives and doctors are still confused regarding the possibility of liability, the speed of decision-making, and the interpretation of the principle of acting in the best interest of the patient. In this context, the significance of the

---

<sup>1</sup> Vipul Mudgal, *End-of-Life Care and Constitutional Morality under Article 21*, JCAL (2025)

<sup>2</sup> *Harish Rana v Union of India* 2026 INSC 222

“Harish Rana legacy” transcends its importance as an interpretative success, and emerges as the tipping point of India's endeavor towards achieving a balance between the constitutionality of the issue and the medical aspect of it. It highlights the requirement for a more consistent legal regime, along with appropriate institutional frameworks and clinical practices which are based on ethical considerations, to make sure that the rights to die with dignity is no longer only talked about in the courtroom, but implemented as an actual process within hospitals.

## STATEMENT OF THE PROBLEM

The major problem identified by the research relates to the significant discrepancy that exists between the judicial guidelines on right-to-die issues as recognized under Article 21 of the Constitution and its actual application in clinical and hospital settings and homes within the Indian context as revealed through recent jurisprudence leading up to the Harish Rana case. While the Apex Court in India has gradually widened the ambit of Article 21 to include the concept of passive euthanasia and established various procedures for withdrawal of treatment and even categorized CANH as a form of treatment, it has become challenging to implement these guidelines in practice owing to procedural complications and lack of an enabling legislation. These gaps lead to confusion among doctors, distress among the family members both emotionally and financially, as well as inconsistent implementation of end-of-life care decisions by different healthcare facilities. The lack of clarity associated with the “best interest” criteria coupled with the dependence on medical panels that are not necessarily protected from possible subjectivity further raises ethical issues associated with this practice. Thus, there is an urgent necessity to analyze whether or not the current judicial framework sufficiently protects patients’ right to dignified and effective end-of-life care decision making.

## RESEARCH OBJECTIVES

- To analyse the development of India’s euthanasia with reference to Article 21 and the rights to die with dignity.
- To examine how the Supreme Court in the Harish Rana judgment operationalizes passive euthanasia guidelines.
- To assess the gap between judicially formulated euthanasia guidelines and their practical implementation in clinical and bedside healthcare settings in India.

## RESEARCH QUESTIONS

1. How has the interpretation of the right to die with dignity changed in the Indian legal context pertaining to end-of-life care under Article 21 of the Constitution?
2. How does the classification of CANH as medical treatment influence decision-making in passive euthanasia cases?
3. What are the shortcomings of the "best interest of the patient" criterion in guaranteeing end-of-life decision-making that is ethical and consistent?

## HYPOTHESIS

Judicially framed guidelines on passive euthanasia in India, though constitutionally robust, are not effectively implemented in clinical settings due to procedural, institutional, and awareness-related barriers. Strengthening integrated palliative care systems and simplifying medico-legal decision-making frameworks is likely to improve alignment between legal standards and bedside end-of-life care practices.

## LITERATURE REVIEW

According to Venkateshan (2026)<sup>3</sup>, one of the main concerns in the jurisprudence of assisted death is the making of decisions for patient who cannot make informed decisions, especially for patients in a persistent vegetative state. The journey from the Aruna Shanbaug case to Common Cause case and currently Harish Rana case shows how the court is becoming more inclined towards recognizing the right of a person under Article 21 to end his/her life with dignity. Where the Shanbaug case came under criticism for preferring the will of the caregiver over the wishes of the patient, the Common Cause judgment provided certain safeguard and recognized advance directives. The Harish Rana case further emphasized that assisted nutrition and hydration is a form of medical treatment that can be discontinued if futile.

Somnath Chatterjee (2026)<sup>4</sup> The 2026 Harish Rana ruling marks another major step in India's increasingly sophisticated system of end-of-life decisions as it reaffirms the principle of dignified death and provides a clearer perspective regarding the issue of withdrawing life-sustaining treatment. In literature dealing with end-of-life decisions, there is a clear progression

---

<sup>3</sup> Venkateshan, What the Harish Rana judgment means for the right to die with dignity in India, Frontline, Mar 16, 2026

<sup>4</sup> Somnath Chatterjee, Why the Harish Rana Judgment is a New Dawn <https://prakriyahospitals.com/hospital/why-the-harish-rana-judgment-is-a-new-dawn-for-dignity-in-india/>

towards re-evaluating such decisions as being part of ethically and medically sound EOLC, based on patients' welfare, autonomy, and suffering rather than considering them passive euthanasia. The ruling takes into account previous decisions made by India's Supreme Court that granted citizens the right to a dignified death, while shedding more light on withholding and withdrawing clinically assisted nutrition as well as emphasizing the necessity of palliative care in such situations. Medical experts maintain that using specific terms like "withholding or withdrawing life-sustaining treatments" helps avoid unnecessary ethical controversy as EOLC is not considered active euthanasia – an illegal procedure. Thus, the 2026 judgment is seen as a breakthrough in the history of medical ethics and practice in India.

Shivani Mody (2026)<sup>5</sup> highlights the evolution of recognition of right to die with dignity as part of Article 21 of the Constitution. In the case of Harish Rana, the legal framework is now strengthened as the judgment makes clear the requirement to balance medical futility with consideration for values, wishes, and personal situation of the individual. One particular problem highlighted in the judgment was addressed as the Court clarified the term CANH as being medical treatment, thus coming under withdrawal procedures. Efforts were also made in this case to streamline the process of treatment withdrawal by establishing medical practitioner committees and other measures. As pointed out by experts, even as there has been considerable progress in this matter, the problem remains one of lack of appropriate legislation to cover the rights to death with dignity.

According to Thota and Ramanjulu (2026)<sup>6</sup>, the Harish Rana case represents a landmark decision in India's laws relating to end-of-life care insofar as it marks a shift from whether withdrawal of CANH is legally permissible to acknowledging the ethical obligation to withdraw treatment where the patient cannot derive any benefit from it. The ruling recognizes that CANH is a form of medical treatment which can be withdrawn, reasserts that the right to live with dignity guaranteed under Article 21 also entails the right to die with dignity, and appreciates that families' decision to withdraw treatment as an expression of compassionate care, not negligence. Notably, there is no ethical distinction between withholding and withdrawing life-prolonging treatment since both aim at sparing patients from futile and painful treatments. In spite of the availability of legal framework and guidelines on end-of-life care,

---

<sup>5</sup> Shivani Mody, *The Right to Die with Dignity: Indian Supreme Court in Harish Rana v. Union of India*, Oxford University Hub, 2026

<sup>6</sup> Thota RS and Ramanjulu *End-of-Life Care in India: Withholding and Withdrawal after the Harish Rana Judgement*. *Indian J Palliat Care*. 2026

their implementation in hospitals is problematic owing to lack of clinician competence in talking about death, poor use of advance directives, among other factors. Essentially, the verdict should motivate health professionals to take into account patient ethics in delivering care.

Paavan Sidhu & Hunar Choudhary (2026)<sup>7</sup> paper examines the recently passed Supreme Court Judgment on *Harish Rana v. Union of India*<sup>1</sup>. This is a landmark case since it became possible to allow death of a person living in a vegetative state after recognizing that the suffering was unnecessary because he was alive artificially thanks to the help of medical professionals. This case has brought change to the attitude of Indian courts towards the 'Right to Die' because it was never granted in previous decisions. The paper provides a discussion about the major issues considered in the case, as well as the clarifications and interpretations made by the Court. In this case, the court provided a unique decision regarding the problem of right to die with dignity. It goes beyond this right to make sure that there is no artificial prolongation of human life based on the principle of moral and legal ethics. In addition, this ruling finally removed the dilemma in the attitude of the judiciary concerning the issue of the right to die.

### **JUDICIAL EVOLUTION OF END-OF-LIFE LAW IN INDIA**

The development of legal principles pertaining to end-of-life decision making in India can be attributed to the evolving constitutional interpretations of Article 21 which moved away from a purely life-preserving position to one that gradually integrated principles relating to dignity, autonomy and medical ethics. It must be noted that in earlier stages of Indian constitutional jurisprudence, Article 21 was considered to be the obligations on the part of the State to ensure the preservation of life.

It was only later, after several years of judicial pronouncements, that this definition of life was expanded to include qualities such as the dignity of suffering and medical autonomy. Such an evolution can be attributed to the expanding scope of Article 21 jurisprudence during which the Supreme Court recognized the rights to privacy, bodily integrity and informed consent as part of Article 21. As a result, the issue of end-of-life treatment became even more sensitive in that it demanded a careful balancing of the sanctity of life and absence of suffering.<sup>8</sup>

---

<sup>7</sup> Paavan Sidhu & Hunar Choudhary, *The Jurisprudence of a Dignified Exit*, IJLLR, 2026

<sup>8</sup> R. K. Sharma & Meenakshi Verma, *Best Interest Standard in Indian Euthanasia Jurisprudence: Medical and Legal Perspectives*, *jmel* 46-52 (2025)

An important doctrine emerging out of this trend is the permissibility of passive euthanasia within constitutional boundaries, provided that certain stringent criteria are met. It is pertinent to note that the Apex Court has always been consistent on the point that although killing of life cannot be accepted, withholding or withdrawing life-sustaining treatment from the patient, in situations where there exists no hope of survival, can be done, especially in accordance with the best interest of the individual concerned.

*Maruti Shripati Dubal v. State of Maharashtra*<sup>9</sup> It was decided by the court that the rights to life guaranteed by Article 21 included the rights to die, thereby invalidating Section 309 as being unconstitutional. The court stated that compelling a person to remain alive against his wishes when he is suffering unbearably amounts to a violation of his personal freedom and dignity. *Gian Kaur v. State of Punjab*<sup>10</sup> Court reversed its earlier decision and ruled that the right to life guaranteed by Article 21 did not comprise the rights to die. The Court reiterated that life was to be preserved and, therefore, it could not be treated as a fundamental right to commit suicide. But the Supreme Court admitted that there may be a need to consider the “rights to die with dignity” at the last stage of life.

*Aruna Shanbaug v. UOI*<sup>11</sup> SCI had provisions for passive euthanasia with proper precautions, where life support could be withdrawn in some circumstances. There were proper procedures and steps that were to be followed and required the permission of the High Court. *Common Cause v. UOI*<sup>12</sup> It is true that the Court has affirmed the legality of passive euthanasia and acknowledged the Rights to Die with Dignity under Article 21, while also approving living wills. This was achieved through striking a delicate balance between the principle of autonomy and precautions against any abuses.

Nonetheless, even in light of these developments, there still exists a body of jurisprudence that is dominated by judicial pronouncements and heavily relies on the facts of each individual case. Lacking adequate legislation, judicial guidelines have become the de facto laws with considerable room left for interpretation and application, particularly in terms of concepts like "Best Interests" and "Medical Futility." This is the legal backdrop against which the Harish Rana decision should be analyzed.

---

<sup>9</sup> 1987 Cri LJ 743 (Bom)

<sup>10</sup> (1996) 2 SCC 648

<sup>11</sup> (2011) 4 SCC 454

<sup>12</sup> (2018) 5 SCC 1

## ANALYSIS OF THE HARISH RANA JUDGMENT

The case of *Harish Rana v. UOI*<sup>13</sup> is the first case wherein the doctrine of passive euthanasia in India has been applied directly and consistently in a chronic situation with PVS. The judgment whereby the Court allowed the withdrawal of CANH is, in essence, a doctrinal extension of prior jurisprudence and an enhancement of its practical applications.

One such doctrine is that of classifying CANH as “medical treatment”. This is significant since it has for long been uncertain whether this constitutes either basic care or medical treatment. In finding that CANH entails medical treatment since it involves clinical involvement and technological intervention, the Court found that it can be withdrawn under passive euthanasia laws. This brings Indian law in line with foreign countries wherein artificial nutrition and hydration qualify as medical treatment.

Further, the case also contributed significantly through the development of the “best interest of the patient test.” Here, the court used several factors such as the medical prognosis of the patient, the chances of his recovery, the issue of dignity for the patient, and his presumed preferences. This test also contained the concept of substituted judgment, where the judges had to decide on behalf of the patient, and this could be done only after determining how the patient himself would decide if he were competent.<sup>14</sup>

The Court also put heavy emphasis on the conclusions of the medical boards, stating that the illness of the patient is irreversible and that the ongoing treatment lacks any purpose of therapy. Thus, it can be said that medical opinion plays an important role in decisions regarding end-of-life care. It also gives rise to the issue of dependency of judicial judgment on medical certificates. It can give the impression that the courts give away their normative power to medical clinics that have no accountability framework. It is crucial to note that the Court reiterated that the key issue here is not whether the life must be ended, but whether there is any purpose of continuing treatment. This gives a new dimension to the discussion on the doctrine of end-of-life care.<sup>15</sup>

---

<sup>13</sup> *Harish Rana v Union of India* 2026 INSC 222

<sup>14</sup> Sumayya Akbarali Sayyed, *Judicial Evolution of Passive Euthanasia Culminating in Harish Rana*, *IJLM&H*(2026)

<sup>15</sup> *Harish Rana v Union of India* <https://vidhilegalpolicy.in/research/harish-rana-v-union-of-india/>

## LEGAL AND CONSTITUTIONAL FRAMEWORK GOVERNING END-OF-LIFE CARE IN INDIA

The constitutional basis for passive euthanasia is rooted in Article 21, which grants every individual the rights to life and liberty. The meaning of this fundamental right, however, has evolved through judicial interpretations such that the right not only includes the guarantee of life itself but also the rights to live with dignity, upon which end-of-life jurisprudence revolves. This dignitarian approach to human rights enables the recognition by Court of cases wherein, under certain situations, especially where patients are in irreversible medical conditions, the right to life entails the right to death with dignity, or the rights to avoid protracted suffering in futile artificial life-sustaining mechanisms. In addition to the right to life (Article 21), the right to equality (Article 14) ensures that there should be a consistent manner for deciding on withdrawing treatment.

In relation to criminal laws, there is a definitive difference among active and passive euthanasia in India. Active euthanasia, where there is an active act of killing carried out, is entirely barred in India under the Bharatiya Nyaya Sanhita, 2023, specifically clauses analogous to Section 100 (culpable homicide not amounting to murder) and Section 101 (murder).<sup>16</sup> The provision ensures that every intentional action leading to death will be punishable under the law. On the other hand, passive euthanasia is different because it involves a scenario where medical personnel withdraw or withhold treatment that may lead to the death of the patient due to the underlying disease.

The regulation that provides guidance in terms of legal framework with regard to passive euthanasia can be traced within the context of professional conduct of medical practitioners and ethics in medicine. According to the Indian Medical Council Regulations, 2002, operationalized under the National Medical Commission regime, it is the responsibility of every physician to give respect to patient's autonomy and to do whatever is in the best interests of the patient. Withholding or withdrawing life support becomes legally permissible in such instances. Doctors must also follow the principles of beneficence and non-maleficence by ensuring that the decision regarding treatments does not just extend the life of an individual biologically without any significant advantage.

---

<sup>16</sup> <https://blog.iplayers.in/culpable-homicide-under-indian-penal-code/>

The process and practice related to passive euthanasia have been formulated largely through the judicial guidance provided in cases such as *Common Cause v. UOI*<sup>17</sup>. This provides a systematic two-level medical board structure consisting of primary and secondary Medical Boards for determining medical futility and deciding on whether the withdrawal of treatments would be beneficial for the patient. The concept of Advance Medical Directives, which are popularly known as living wills, is also accepted under Indian law where people are allowed to give directions in advance about their wishes with respect to medical treatments in the event of becoming incompetent in the future.

### **GAP AMONG JUDICIAL GUIDELINES AND CLINICAL PRACTICES**

Among many issues that come out in connection with the study of end-of-life jurisprudence is the discrepancy between the guidelines prescribed by courts and the practice of implementing them at the patient's bedside. Although much effort was spent on elaborating elaborate procedures, they still prove to be hard to implement in clinical practice, especially under conditions of poor healthcare. The first and foremost problem concerns the complexity of procedure implementation. The need to consult several medical boards and obtain appropriate documentation may entail serious time delays which, being applied in the setting of intensive care units, may lead to an extended biological life span devoid of any medical value whatsoever.

The other key problem associated with the process involves the subjectivity associated with terms like "medical futility" and "best interest." Despite efforts by the judiciary to try and make these terms more standardized, there continues to be a lot of subjectivity involved. In addition to this, the lack of training among medical practitioners in this area contributes greatly to this subjectivity.<sup>18</sup> The role played by family members in such cases is important but at the same time it adds another layer of complexity to the matter. Emotional stress, social pressure and financial burden associated with being in such a situation could play a part in the decision-making process. Even though the court systems acknowledge the significance of family involvement, it does not take into consideration other aspects that might affect the process of reaching an informed conclusion. There are also institutional aspects that need to be considered when discussing the problems associated with the inconsistency among law and practice. Many

---

<sup>17</sup> (2018) 5 SCC 1

<sup>18</sup> Anvesha Rana, *Dignity in Death: The Supreme Court's Passive Euthanasia Ruling in the Harish Rana Case*, IJLR (2026)

hospitals have no ethical committees in place or palliative care centers, especially outside large cities.

## **ETHICAL DIMENSIONS OF END-OF-LIFE DECISION MAKING**

This ethical context is characterized by conflicting values of autonomy, beneficence, non-maleficence, and justice. The application of these values may pose dilemmas in end-of-life care when they refer to patients whose condition is not reversible and who lack the ability to communicate their desires. While autonomy is the cornerstone of modern medicine because it respects patients' rights, in incapacitated individuals, it needs to be reconstructed using substituted judgments or presumed preference. This leads to ethical dilemmas concerning the genuineness of decision-making for those who have lost the ability to make decisions and their dignity.

The values of beneficence and non-maleficence impose responsibilities on health care professionals to do their best for the patients but avoid any harm. In end-of-life situations, it may become unclear whether some interventions that prolong biological life constitute harm or not. Prolonged existence may be considered harmful because it can deprive the person of dignity. At the same time, the decision to withdraw treatment may be interpreted as abandonment and thus harm the patient. The concept of justice brings in issues of allocation of resources and the issue of accessibility to intense care. Extended use of life support under irreversible circumstances is a considerable burden for health-care systems, and therefore raises issues of distributive justice. Nevertheless, it should be understood that ethical appeal to issues of resources should not be allowed to undermine the inherent dignity of individual life. Social and cultural values bring yet another dimension to ethical deliberations.<sup>19</sup> In India, issues like family obligations, religious belief, and social views about death greatly impact end-of-life decisions, although these might sometimes be in conflict with the individual-based considerations of constitution-based jurisprudence.<sup>20</sup>

## **CRITICAL EVALUATIONS**

Judicial intervention in end-of-life treatment exhibits a combination of progressive thinking and institutional drawbacks. In the first place, the ability of the court to extend the constitutional

---

<sup>19</sup> Timms and Govind N. Withdrawal of care at end of life: Ethical and legal perspectives, *IJME* (2026)

<sup>20</sup> Rishabh Gandhi, *Dying With Dignity: India's Evolving End-Of-Life Jurisprudence*, *Livelaw* (2026)

definition of dignity to mean a dignified death indicates an important development in constitutional morality. It means that forced biological survival might sometimes be incompatible with basic human rights.

At the same time, the adoption of judicial guidelines instead of legislation in this case might indicate an excessive burden imposed upon the judiciary and create some problems related to its sustainability. Courts are supposed to act in certain cases rather than regulate certain spheres for an extended period of time. In addition, there is no legislative basis for what courts do. Finally, although doctors are burdened with a lot of responsibility in terms of choosing between ending life and keeping a person alive in case of futility of medical treatment, there is no institutional basis for such decisions or training for physicians.

Though the “best interest” criterion is highly sound and valid in principle, it lacks operational clarity because it is difficult to apply. There is a lack of clearly defined statutory guidelines and decision-making instruments to provide a clearer understanding of what constitutes an individual’s best interests. Lastly, the approach fails to provide sufficient attention to the systemic problems that exist regarding the uneven distribution of end-of-life healthcare facilities. The right to end life with dignity cannot be realized if end-of-life care relies significantly on the availability of such facilities.

## **CONCLUSION AND SUGGESTIONS**

The Harish Rana jurisprudence is thus an important landmark in India’s legislation regarding death, for here the constitutional principles of dignity, autonomy, and compassionate treatment find their practical medical and legal application. Having confirmed the legitimacy of withholding clinically assisted nutrition and hydration provided that specific criteria are met, the Court went further than merely acknowledging patients' right to dignified death. On the other hand, this judgment highlights a recurring problem of a conceptual difference between judicially formulated approaches to the issue and their bedside implementation, where the decision making may be influenced not just by legal concerns, but also by factors such as the institution's preparedness, the medical ability to provide care, and the emotional state of both patients' relatives and health professionals.

In a normative sense, the ruling is of considerable value, for it makes sure that the Indian healthcare sector operates under clearly expressed principles and values which put dignity

above any biological considerations. However, the lack of a detailed legislative framework leads to an overreliance on judicial guidelines which renders the system prone to inconsistency and interpretation differences. In terms of implementation, there is still a considerable disparity between theory and practice. Not all medical establishments have ethics committees and a specialized palliative team with an existing set of procedures regarding end-of-life issues. In such circumstances, delays, caution by physicians, and stress for relatives who have to make difficult decisions when emotionally affected become possible outcomes. Thus, without sufficient infrastructure, even carefully prepared judicial guidelines may face problems in practical implementation, especially in rural areas and in institutions that are not tertiary hospitals.

To solve the problem of lack of infrastructure in addition to legislative inconsistencies, a holistic approach should be taken. First, Parliament should introduce the necessary end-of-life care legislation. Secondly, there is a need to enhance the capacity building of institutions by way of making the integration of palliative care, hospital ethics committee, and specialized training of medical professionals in law and ethics compulsory. Third, there needs to be an increased awareness about advanced medical directives to minimize the use of substituted judgments. Lastly, the principle of dignity needs to be institutionalized at all times.

## REFERENCES

1. Vipul Mudgal, End-of-Life Care and Constitutional Morality under Article 21, JCAL (2025)
2. Venkateshan, What the Harish Rana judgment means for the right to die with dignity in India, Frontline, Mar 16, 2026
3. Shivani Mody, The Right to Die with Dignity: Indian Supreme Court in Harish Rana v. Union of India, Oxford University Hub, 2026
4. Thota RS and Ramanjulu End-of-Life Care in India: Withholding and Withdrawal after the Harish Rana Judgement. Indian J Palliat Care. 2026
5. Paavan Sidhu & Hunar Choudhary, The Jurisprudence of a Dignified Exit, IJLLR, 2026
6. R. K. Sharma & Meenakshi Verma, Best Interest Standard in Indian Euthanasia Jurisprudence: Medical and Legal Perspectives, jmel 46-52 (2025)
7. Sumayya Akbarali Sayyed, Judicial Evolution of Passive Euthanasia Culminating in Harish Rana, IJLM&H (2026)

8. Anvesha Rana, Dignity in Death: The Supreme Court's Passive Euthanasia Ruling in the Harish Rana Case, IJLR (2026)
9. Timms and Govind N. Withdrawal of care at end of life: Ethical and legal perspectives, IJME (2026)
10. Rishabh Gandhi, Dying With Dignity: India's Evolving End-Of-Life Jurisprudence, Livelaw (2026)
11. Harish Rana v Union of India <https://vidhilegalpolicy.in/research/harish-rana-v-union-of-india/>
12. Somnath Chatterjee, Why the Harish Rana Judgment is a New Dawn <https://prakriyahospitals.com/hospital/why-the-harish-rana-judgment-is-a-new-dawn-for-dignity-in-india/>
13. <https://blog.ipleaders.in/culpable-homicide-under-indian-penal-code/>



WHITE BLACK  
LEGAL