IJCRT.ORG ISSN : 2320-2882

INTERNATIONAL JOURNAL OF CREATIVE RESEARCH THOUGHTS (IJCRT)

An International Open Access, Peer-reviewed, Refereed Journal

EUTHANASIA: JUDICIAL TRENDS

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Abstract

Euthanasia -the deliberate ending of a person's life to relieve suffering -remains one of the most doctrinally unsettled areas of Indian constitutional law. In the continued absence of dedicated legislation, the contours of the right to die have been shaped almost entirely through a sequence of Supreme Court decisions stretching from P. Rathinam v. Union of India[1] in 1994 to Harish Rana v. Union of India[2] in 2026. This paper traces that judicial trajectory, examines the constitutional reasoning underlying the recognition of passive euthanasia and the living will, and evaluates the procedural reforms introduced by the 2023 modification of the Common Cause guidelines. It argues that Indian judicial trends reveal a cautious, incremental expansion of the right to die with dignity, marked by a persistent unwillingness to permit active euthanasia and a growing recognition that excessive procedural safeguards can themselves defeat the very dignity interest that Article 21 protects.

Keywords: - Euthanasia, Judicial Trends, Suicide, Constitutionality

1. Introduction

Euthanasia is conventionally classified along two axes: active versus passive, and voluntary versus non-voluntary or involuntary. “Active euthanasia involves a deliberate act -typically the administration of a lethal substance- intended to cause death, while passive euthanasia involves the withholding or withdrawal of life-sustaining treatment, allowing the underlying condition to take its natural course. Indian criminal law, through Section 309 of the erstwhile Indian Penal Code, 1860 and now Section 224 of the Bharatiya Nyaya Sanhita, 2023”, historically criminalised the attempt to commit suicide, while Section 300 and its successor provisions treat any act causing death at the victim's request as culpable homicide, since consent is not a defence to killing under the general law.[3] It is within this restrictive statutory backdrop, and in the continued absence of a dedicated euthanasia statute, that the Supreme Court has had to locate whatever right to die the Constitution protects, drawing that right almost entirely out of the guarantee of life and personal liberty under Article 21.

1P. Rathinam v. Union of India, (1994) 3 SCC 394.
2Harish Rana v. Union of India, 2026 SCC OnLine SC 358.
3Bharatiya Nyaya Sanhita, 2023, ss 224, 100-105 (corresponding to the Indian Penal Code, 1860, ss 309, 299-300); Gian Kaur v. State of Punjab, (1996) 2 SCC 648, ¶¶ 22-24.

2. The Early Trend: Right to Life and the Question of a Right to Die

The judicial trend begins with a direct conflict between two Division Bench decisions on whether Section 309 of the Indian Penal Code, criminalising attempted suicide, was constitutionally valid. In "P. Rathinam v. Union of India, a two-Judge Bench held that the right to life under Article 21 logically includes a right not to live, and struck down Section 309 as violative of Articles 14 and 21", reasoning that punishing a person who had already suffered the ordeal of an unsuccessful suicide attempt was both unreasonable and cruel.[4] This position was short-lived. A five-Judge Constitution Bench in Gian Kaur v. State of Punjab overruled Rathinam, holding that the 'right to life' guaranteed by Article 21 is essentially a right consistent with dignity of living, and that the extinction of life cannot be read as a facet of that right merely because the two are grammatically opposed; the Court held that the right to die was not a fundamental right and upheld the constitutionality of Section 309.[5] Significantly, however, the Bench in Gian Kaur introduced a qualification that would prove decisive for the later development of the law: it observed, in obiter, that the 'right to live with human dignity' could be understood to include a right to die with dignity, but confined this to the process of natural death that had already commenced, expressly distinguishing it from an unnatural termination of life through suicide.[6] This distinction between accelerating an already-commenced dying process and prematurely ending a healthy life became the conceptual seed from which the Court's later passive euthanasia jurisprudence grew.

3. Aruna Shanbaug: The First Recognition of Passive Euthanasia

The question left open in Gian Kaur was squarely presented fifteen years later in Aruna Ramachandra Shanbaug v. Union of India, a writ petition filed by a journalist on behalf of a nurse who had remained in a persistent vegetative state for over thirty-seven years following a brutal sexual assault, seeking a direction that the hospital be permitted to stop feeding her.[7] A two-Judge Bench, speaking through Justice Markandey Katju, declined the specific relief sought -since the hospital staff who had cared for Aruna Shanbaug for decades did not wish to withdraw her feeding -but took the opportunity to lay down, for the first time, a comprehensive legal framework recognising passive euthanasia in India. The Court held that passive euthanasia, being the withdrawal or withholding of life-sustaining treatment, could be permitted in exceptional circumstances under the strict safeguards laid down in the judgment, whereas active euthanasia remained wholly illegal.[8] Crucially, since no Indian legislation existed on the subject, the Court held that a decision to withdraw life support in the case of an incompetent person could be taken only by the parents, spouse or next friend, and required the approval of the jurisdictional High Court acting under its parens patriae jurisdiction, following a report from a medical board constituted for the purpose -a cumbersome, litigation-dependent procedure that the Court itself acknowledged was a stop-gap measure pending legislation by Parliament.[9] Aruna Shanbaug is therefore best understood as a cautious, case-specific judicial trend: it recognised the constitutional legitimacy of passive euthanasia in principle while simultaneously constructing a High-Court-centred procedural gate that made the right, as a practical matter, available only through litigation rather than through private, anticipatory decision-making by the patient.

4P. Rathinam v. Union of India, (1994) 3 SCC 394, ¶¶ 21-25.
5Gian Kaur v. State of Punjab, (1996) 2 SCC 648, ¶¶ 22, 33.
6Ibid, ¶ 24.
7Aruna Ramachandra Shanbaug v. Union of India, (2011) 4 SCC 454.
8Ibid, ¶¶ 39, 121, 125.
9Ibid ¶¶ 124-125; see also "Law Commission of India, 196th Report on Medical Treatment to Terminally Ill Patients (For the Protection of Patients and Medical Practitioners) (2006)".

4. Common Cause (2018): The Constitutional Right to a Living Will

The next, and most consequential, shift in judicial trend occurred in Common Cause (A Regd. Society) v. Union of India, where a five-Judge Constitution Bench was called upon to decide whether a person of sound mind could execute an advance medical directive -commonly termed a 'living will' -specifying in advance the medical treatment they would wish to refuse should they become incapacitated and unable to communicate.[10] Delivering separate but concurring opinions, the Constitution Bench unanimously held that the right to die with dignity is a fundamental right within the fold of the right to live with dignity guaranteed under Article 21, and that this necessarily includes the right of a competent adult to refuse life-prolonging medical treatment or to withdraw from it, whether contemporaneously or through an advance directive executed while still capable of making an informed choice.[11] Chief Justice Dipak Misra, writing for himself and Justice A.M. Khanwilkar, grounded the right in personal autonomy and self-determination, describing dignity as encompassing 'smoothening the process of dying' rather than accelerating or preventing death artificially, while Justice D.Y. Chandrachud's concurring opinion placed particular emphasis on bodily integrity and the right of a patient to refuse invasive medical intervention even where refusal would hasten death.[12] In the absence of parliamentary legislation, the Bench exercised its power under Articles 141 and 142 to lay down exhaustive guidelines governing the execution, safekeeping, and implementation of a living will, until such time as Parliament enacted a law on the subject.[13] These 2018 guidelines, however, replicated much of the institutional caution of Aruna Shanbaug: a living will required execution before a Judicial Magistrate of First Class, custody of the document with the Magistrate and a local self-government authority, examination by both a primary and a secondary medical board, and, in case of any conflict, resort to the jurisdictional High Court -a multi-layered process that practitioners and commentators quickly identified as so cumbersome as to render the right largely illusory in practice.[14]

5. Common Cause (2023): Simplifying the Procedure

Recognising that the 2018 procedure had rendered the living will impractical, the Indian Society of Critical Care Medicine filed a miscellaneous application before the same Constitution Bench (differently constituted) seeking clarification and simplification of the guidelines. In its order of 24 January 2023, the Bench comprising Justices K.M. Joseph, Ajay Rastogi, Aniruddha Bose, Hrishikesh Roy and C.T. Ravikumar substantially modified the 2018 framework.[15] The requirement of execution and countersignature before a Judicial Magistrate of First Class was dispensed with; a living will may now be executed by signing it in the presence of two independent witnesses, followed by attestation before a Notary or a Gazetted Officer.[16] The role of the medical board was similarly streamlined: the primary medical board's opinion must now be conveyed within forty-eight hours, and the requirement of an additional, external secondary board drawn from a district-level panel was retained but simplified, with the hospital administrator's approval substituted in several respects for what had previously required direct judicial or magisterial involvement.[17] The 2023 order thus reflects an important shift in judicial trend: whereas Aruna Shanbaug and the original Common Cause guidelines had proceeded on the assumption that the risk of misuse justified maximal procedural insulation, the 2023 modification signals the Court's recognition that excessive procedure is itself a threat to

10Common Cause (A Regd. Society) v. Union of India, (2018) 5 SCC 1.
11Common Cause (A Regd. Society) v. Union of India, (2018) 5 SCC 1, ¶¶ 90-91 (per Misra, C.J.); ¶ 195 (per Chandrachud, J.).
12Ibid, ¶¶ 100-104 (per Misra, C.J.); ¶¶ 199-201 (per Chandrachud, J.).
13Common Cause (A Regd. Society) v. Union of India, (2018) 5 SCC 1, ¶ 202.
14Ibid, ¶ 191; Indian Society of Critical Care Medicine, Miscellaneous Application No. 1699 of 2019, seeking clarification of the 2018 guidelines.
15Ibid, ¶¶ 8-9.
16"Common Cause (A Regd. Society) v. Union of India, 2023 SCC OnLine SC 99, ¶ 9(iv); Ministry of Health and Family Welfare, Guidelines for Withdrawal of Life Support in Terminally Ill Patients" (February 2023).
17Ibid, ¶ 9(x)-(xiv).

the dignity interest that Article 21 protects, since a right that cannot practically be exercised offers illusory protection.

6. Harish Rana v. Union of India (2026): The First Judicial Implementation

The most recent milestone in this trend is Harish Rana v. Union of India, decided on 11 March 2026 by a Bench of Justices J.B. Pardiwala and K.V. Viswanathan, widely regarded as the first instance in which the Supreme Court itself directly sanctioned the withdrawal of life-sustaining treatment for a named individual patient, rather than merely laying down guidelines for future cases.[18] The petitioner had remained in a permanent vegetative state for over thirteen years following a traumatic brain injury, and the matter reached the Supreme Court after the Delhi High Court had dismissed the initial petition in 2024. The Bench held that clinically assisted nutrition and hydration administered through a feeding tube constitutes 'medical treatment' within the meaning of the Common Cause framework, and not mere 'basic care', and may therefore be withdrawn where the statutory and medical-board safeguards are satisfied -an important clarification, since the distinction between treatment (which may be withdrawn) and basic care such as nursing, hygiene and pain relief (which may not be withdrawn) had remained a source of uncertainty since Aruna Shanbaug.[19] The Court further waived the mandatory thirty-day period for reconsideration ordinarily prescribed under the guidelines, holding that the patient's protracted and medically hopeless condition warranted an expedited course.[20] Harish Rana therefore marks the point at which India's passive euthanasia jurisprudence moved from the articulation of abstract guidelines to their concrete, individualised application -arguably completing the trajectory begun in Gian Kaur's obiter recognition of a dignified dying process.

7. Analysis: The Direction of Judicial Trends

Read together, these decisions disclose four consistent trends. First, the Supreme Court has steadfastly refused to extend constitutional protection to active euthanasia or physician-assisted death involving a deliberate lethal act, confining the right recognised under Article 21 exclusively to the withholding or withdrawal of treatment that artificially prolongs an already-irreversible dying process.[21] Second, the Court has been candidly aware that it is legislating in the absence of parliamentary action, repeatedly emphasising that its guidelines will remain in force only 'till Parliament enacts legislation'[22], a call that has gone unanswered for over a decade despite recommendations in the Law Commission of India's 196th and 241st Reports.[23] Third, there is a discernible procedural liberalisation over time: the shift from mandatory Magistrate and High Court involvement in Aruna Shanbaug and the 2018 Common Cause guidelines to notarised self-execution and expedited medical board timelines in the 2023 modification illustrates the Court's growing sensitivity to the gap between a right recognised on paper and a right that is realistically exercisable. Fourth, and finally, Harish Rana suggests that the Court is now prepared to apply this framework directly and expeditiously to deserving individual cases rather than treating every application as an occasion to revisit first principles, indicating a maturing and increasingly confident body of doctrine.

18Harish Rana v. Union of India, 2026 SCC OnLine SC 358.
19Ibid; cf. Aruna Ramachandra Shanbaug v. Union of India, (2011) 4 SCC 454, ¶ 122, distinguishing withdrawal of treatment from withdrawal of basic nursing care.
20Harish Rana v. Union of India, 2026 SCC OnLine SC 358.
21"Aruna Ramachandra Shanbaug v. Union of India, (2011) 4 SCC 454, ¶ 39; Common Cause (A Regd. Society) v. Union of India, (2018) 5 SCC 1, ¶ 100".
22Common Cause (A Regd. Society) v. Union of India, (2018) 5 SCC 1, ¶ 202; Aruna Ramachandra Shanbaug v. Union of India, (2011) 4 SCC 454, ¶ 125.
23"Law Commission of India, 196th Report on Medical Treatment to Terminally Ill Patients (2006); Law Commission of India, 241st Report on Passive Euthanasia — A Relook (2012)".

8. Conclusion

The judicial trend in India on euthanasia has been one of careful, incremental constitutionalisation rather than dramatic doctrinal upheaval. Beginning with Gian Kaur's narrow acknowledgment that a dignified death forms part of Article 21, through Aruna Shanbaug's recognition of passive euthanasia under strict judicial supervision, to Common Cause's elevation of the living will to a fundamental right and its subsequent procedural simplification in 2023, and finally to Harish Rana's direct application of that framework, the Supreme Court has built, case by case, a body of law that Parliament has yet to codify. This continuing legislative silence leaves the right to die with dignity dependent on judicially evolved guidelines that, however progressively refined, lack the certainty, public accessibility and democratic legitimacy that only a dedicated statute can supply. The judicial trend, in other words, has done what courts can properly do - construe the Constitution to protect dignity in dying -but the task of building a comprehensive, statutory end-of-life care framework, addressing palliative care, hospice regulation, and the precise institutional machinery for verifying and implementing advance directives, remains, as the Supreme Court itself has repeatedly observed, a task for the legislature