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Yearbook *of* Anesthesiology

16

Indian College of Anaesthesiologists



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Foreword
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CHAPTER 19

Dying with Dignity

Bhavna Hooda, Atul Nagarajan, Bharti Wadhwa

ABSTRACT

The Supreme Court's verdict in the Harish Rana case forces India to confront an ethical question: When does preserving life amount to prolonging suffering?

The landscape of end-of-life care (EOLC) in India has historically been constrained by bureaucratic paralysis and fear of legal liability. It has now transitioned to a structured, legally sanctioned approach that honors patient autonomy, and anesthesiologists and intensivists can now operate under a streamlined legal framework. Following the landmark 2018 Supreme Court ruling in *Common Cause versus Union of India* and its pivotal January 2023 amendment, the implementation of advance medical directives (AMDs) and the withholding or withdrawing of life-sustaining treatment have become clinically workable. Furthermore, recent judicial developments—most notably the landmark *Harish Rana* judgment—have clarified the boundary between artificial life support and basic humanitarian care. This article reviews the evolution of these directives, details the current practical protocols for hospital medical boards, clarifies terminology in alignment with the Indian Council of Medical Research (ICMR), and outlines the path forward for the anesthesia community in managing the dying patient with dignity.

Keywords: End of life care, euthanasia, Do Not Attempt Resuscitation, common cause judgment, Harish Rana versus Union of India, withholding/withdrawing life-sustaining treatment

KEY POINTS

- The Harish Rana versus Union of India case is the first practical implementation of India's passive euthanasia framework.
- *Common Cause versus Union of India judgment:* Validity of Advance Directives or Living Wills, enabling competent individuals to express their wishes concerning future medical treatment, should they become incapable of communicating those wishes.
- Common Cause 2023 guidelines simplified the process of end-of-life directives by removing the procedural requirement of a judicial magistrate's countersignature and streamlining the Medical Board review.
- Central role of an intensivist in recognizing the triggers for end-of-life care (EOLC), multidisciplinary collaboration including family, shared decision-making on transition to palliative/end of life care, while maintaining ethical, cultural, spiritual, and legal considerations.
- Active euthanasia remains illegal in India and may attract criminal liability under criminal law.

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- Indian Council of Medical Research (ICMR) guidelines on a standardized Do Not Attempt Resuscitation (DNAR) proforma sheet for hospitals to integrate into their policy, ensuring uniform documentation and minimizing ambiguity.
- The Indian Society of Critical Care Medicine/Indian Association of Palliative Care (ISCCM/IAPC) consensus statement on the EOLC pathway defines a clinician-led, patient-centered approach to dignified death within the legal framework.
- Establishing a clear and uniform definition of brain death is the need of the hour to ensure brain-dead patients are granted the right to a dignified death, as enshrined in Article 21 of the Constitution.

INTRODUCTION: THE CRITICAL CARE CONUNDRUM

For decades, the Indian Intensive Care Units (ICUs) have been heavily skewed toward aggressive, maximalist life support. Through a combination of technological advancements in organ support, societal taboos around death, and a fear of litigation, patients are often kept medically alive through invasive interventions long after any hope of meaningful recovery has vanished.

As anesthesiologists and intensivists orchestrating these advanced modalities, we frequently bear the brunt of this ethical and moral conflict. The resulting moral distress within our specialty is prioritizing organ physiology over patient-centricity. In recent years, the intersection of persistent medical advocacy and judicial evolution has fundamentally reshaped our legal standing, offering a practical framework for transitioning patients from futile interventions to structured comfort care while drawing a clear line between medical technology and pain-free, dignified end-of-life transition.

BEYOND SURVIVAL

Modern medicine has become extraordinarily effective at keeping the human body alive. Ventilators, feeding tubes, and other advanced interventions can preserve biological functions for months, years, and even decades. While these technological developments have significantly enhanced healthcare outcomes, they have also generated profound ethical, legal, and constitutional dilemmas.[1] One of the most challenging questions confronting modern medicine is whether life should be artificially prolonged when recovery is medically impossible, and the patient is incapable of experiencing consciousness, autonomy, or dignity. The debate surrounding passive euthanasia and end-of-life decisions lies at the intersection of medicine, ethics, constitutional rights, and human compassion.

Though distancing itself from euthanasia, the World Health Organization (WHO) has often emphasized that the purpose of medicine is not simply to delay death, but also to reduce suffering and improve the quality of life by providing palliative and end-of-life care (EOLC). In many healthcare systems worldwide, palliative care, patient autonomy, and informed end-of-life decisions have been recognized as essential components of medicine.

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THE JUDICIAL JOURNEY

The recognition of the right to life with dignity raises an essential question: to what extent does a person's dignity intersect with the right to choose and bodily autonomy, with the State's paternalistic approach to upholding the sanctity of life? The Supreme Court of India has progressively evolved the jurisprudence through a series of landmark decisions beginning with *Aruna Ramachandra Shanbaug v. Union of India* (2011),[2] followed by the Constitution Bench judgment in *Common Cause versus Union of India* (2018),[3] and culminating recently in the significant decision in *Harish Rana v. Union of India*.[4]

The Right to Die: Constitutional Challenges

Before examining the jurisprudential evolution of euthanasia, it is essential to understand the evolution of the right to die in Indian constitutional law. The Indian Constitution does not explicitly recognize a right to die. Nevertheless, constitutional jurisprudence has progressively expanded the scope of Article 21, which guarantees that no person shall be deprived of life or personal liberty except according to procedure established by law.[5] The first challenge to the sanctity of life was raised before the Bombay High Court in *Maruti Shripati Dubal v. State of Maharashtra*.[6] In a highly controversial decision, the Bombay High Court struck down IPC Section 309 (attempted suicide being punishable) as unconstitutional, arguing that the right to life included the right to die with dignity, especially for persons who were terminally ill or experiencing immense pain.[6] Over the coming decade and several litigations later, the Supreme Court held that the right to life also includes the right not to live, i.e., the right to die, stating a person cannot be compelled to live against their will.[7] At the same time, the Court emphasized that the right to die with dignity and be free from a life of suffering cannot be equated with an active attempt to terminate life.[8]

This crucial distinction served as the foundation for the recognition of passive euthanasia in India; the landmark case of Aruna Shanbaug marking a pivotal moment in the journey toward this acceptance.[2] Aruna Shanbaug, a nurse employed at Mumbai's KEM Hospital, remained in a vegetative state for more than four decades following a brutal assault. Although the Supreme Court declined to permit withdrawal of treatment in Aruna's case, it recognized passive euthanasia, such as withdrawal of life-sustaining treatment (WD-LST)—legally permissible under certain circumstances and laid down guidelines and procedural safeguards. However, it held that active euthanasia, such as by administering a lethal substance, was absolutely impermissible. It is notable, however, that the Court's approach emphasized the *parens patriae* role of the State and the courts.

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Further, the scope of dignity and the right to life were authoritatively examined in the nine-judge bench case of *KS Puttaswamy*.[9] While upholding the conception of the right to privacy within the right to life, the court articulated personal bodily autonomy and self-determination as inviolable, core constitutional values rooted in individual dignity.[9]

This articulation of the right to privacy was foundational in the decision of *Common Cause* dealing with the question of euthanasia.[3] The Common Cause versus Union of India (2018) judgment was groundbreaking, fundamentally redirecting attention from state interests to prioritizing patient autonomy. The Supreme Court of India held that the right to die with dignity is an intrinsic and inseparable facet of the right to life with human dignity guaranteed under Article 21. The Court legally recognized passive euthanasia—the withholding or withdrawing of medical treatment to accelerate the natural end of an imminent, terminal illness—as a constitutional right rooted in individual autonomy, privacy, and bodily integrity. To operationalize this right and protect patient choice even after loss of consciousness, it further recognized the validity of advance medical directives (AMDs) or Living Wills, enabling competent individuals to express their wishes concerning future medical treatment should they become incapable of communicating those wishes, along with establishing robust procedural safeguards to prevent potential misuse. Grounded in the right to personal liberty and self-determination, and departing from the paternalistic approach in *Aruna Shanbaug*, the Court underscored the paramount importance of an individual's decisional autonomy.[3]

Despite its pioneering stance, its procedural framework faced significant criticism for being overtly cumbersome. The need for multiple approvals, extensive documentation, and intricate verification processes often made practical implementation a challenging and unwieldy task. End-of-life directives had to be executed in front of two witnesses, countersigned by a judicial magistrate, and registered. The process also involved a thorough review by Medical Boards and, in case of disputes, by the High Court, which further extended the timelines. Recognizing these concerns, in 2023, a Constitution Bench of the Supreme Court (Common Cause v. Union of India) simplified the process by removing the procedural requirement of a judicial magistrate's countersignature and streamlining the Medical Board review.[10]

The *Harish Rana* decision represents the first practical application of this evolved framework. This paved the way for dignity as a constitutional value, moving beyond mere physical existence to a dignified life.

HARISH RANA VERSUS UNION OF INDIA

On March 11, 2026, the courtroom fell silent as the Hon'ble Supreme Court, in the Harish Rana versus Union of India case, permitted the WD-LST—the

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first practical implementation of India's passive euthanasia framework. The verdict will be remembered as a legal milestone whereby jurisprudence chose compassion over abstraction and dignity over mere biological persistence.

The Story Behind the Litigation

The legal issues examined by the Supreme Court in *Harish Rana Case* arose from the tragic circumstances surrounding him, a promising young engineering student whose life changed irreversibly following a devastating accident in 2013.[4] For more than a decade, Harish remained in a persistent vegetative state. Although basic biological functions were maintained through medical intervention, he was unable to communicate, recognize his family members, express preferences, or exhibit any meaningful signs of cognitive awareness. His survival depended entirely upon medical support, including artificial nutrition and hydration administered through feeding tubes and constant medical supervision. Over the years, his family endured tremendous emotional and financial hardship while caring for him. Medical evaluations consistently concluded that there existed no realistic possibility of neurological recovery—a persistent vegetative state.

Faced with these circumstances, his parents approached the judicial system seeking permission to withdraw life-sustaining treatment. The case eventually reached the Supreme Court, where multiple medical boards were constituted to assess his condition. The medical experts unanimously concluded that the condition was irreversible and that continued treatment provided no therapeutic benefit. The Court was therefore confronted with a difficult but fundamental question: Whether law mandates the indefinite preservation of biological life even when medical science confirms that recovery is impossible, or whether constitutional values permit the withdrawal of life sustaining treatment in such circumstances. The Court ordered Harish Rana to be transferred to the Palliative Care department at All India Institute of Medical Sciences (AIIMS) in New Delhi to ensure the withdrawal of care was conducted systematically and painlessly. Delivered by Justices JB Pardiwala and KV Viswanathan, this court ruling marked the first time an Indian court proactively sanctioned passive euthanasia.[4]

The judgment not only revisits the legal framework governing passive euthanasia but also provides valuable guidance regarding end-of-life decision-making, withdrawal/withholding of life-sustaining treatment, the role of medical professionals, and the responsibilities of courts when confronted with cases involving patients with terminal illnesses and irreversible neurologic states. More importantly, it demonstrates the judiciary's attempt to harmonize constitutional values with evolving principles of medical ethics and patient-centered care.

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Understanding Euthanasia

Internationally, as of 2025, active euthanasia is legal in the Netherlands, Belgium, Canada, Colombia, Ecuador, New Zealand, and a few states of Australia, Portugal, and Spain. While Physician-assisted suicide is legalized in a few odd countries (Germany, Switzerland, and a few US states), passive euthanasia is allowed in many countries across the world, India being one of them. The term originates from the Greek words "eu", meaning "good", and "thanatos", meaning "death." "Good death" simplistically embodies the permitting of a dignified death when living brings about unbearable medical suffering, loss of bodily control, or prolonged dependence on artificial life support. Active euthanasia is a deliberate, overt act of intervention designed to bring about death, say by administering a lethal injection or prescribing medication with the specific intention of ending life.[11] Such conduct remains illegal in India and may attract criminal liability under criminal law.[12] Passive euthanasia, by contrast, involves withholding or withdrawing medical treatment that artificially prolongs life. It does not involve causing death; rather, it allows the underlying medical condition to take its natural course. Withdrawal of ventilatory support, discontinuation of artificial nutrition, and non-initiation of extraordinary life-sustaining interventions, such as dialysis, pacemaker insertion, extracorporeal membrane oxygenation, etc., are common examples.[13]

The distinction between active and passive euthanasia remains central to Indian law. The jurisprudential foundation for passive euthanasia emerges from the expanded understanding of constitutional liberty. The Court has repeatedly emphasized that the constitutional guarantee of life is not confined merely to physical existence. Rather, it encompasses a life lived with dignity, autonomy, and self-respect.[14] The inevitable consequence of this reasoning is that dignity must also accompany the final stages of life. A constitutional system that protects dignity during life cannot disregard dignity at the threshold of death.[15]

END-OF-LIFE DECISIONS: MOVING BEYOND THE EUTHANASIA DEBATE

The core values of the terms "end of life", "hospice", and "comfort care" highlight the profound importance of compassionate and patient-centered support during life's most vulnerable moments. EOLC, as defined by the National Council for Palliative Care (NCPC), is the process that ensures that individuals with advanced, progressive, and incurable illnesses, viz chronic disease progression, acute illnesses, or terminal cancers unresponsive to treatment, receive the best possible quality of life until the very end.[16] It focuses on providing terminally ill patients with compassionate care that addresses physical, psychological, social, spiritual, and existential needs of

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individuals nearing the end of life and prioritizes symptom management, comfort, dignity, and the quality of both life and the dying process. It is fundamentally a person-centered approach that defines a "Good Death"—a compassionate, personalized experience rooted in dignity and respect.

Historically, uncertainty about criminal and civil liability often compelled physicians to continue treatment even when it appeared medically futile.[17] The Supreme Court's decision reassures healthcare providers that those acting in accordance with recognized medical standards and established procedures will receive legal protection. Multidisciplinary and shared decision-making, independent medical boards, transparent documentation, informed consultation with family members, and adherence to established protocols remain essential safeguards. Importantly, the judgment does not diminish the physician's duty to care. Rather, it recognizes that compassionate care is appropriate when it appears medically futile, allowing a natural death while ensuring adequate comfort, dignity, and palliative support.

Recognizing that this period can span from several years to just months or days before death underscores the vital role of timely interventions in providing dignity and comfort during this critical time. The National Hospice and Palliative Care Organization (NHPCO) clearly states that end-of-life or hospice care begins when a diagnosis of a terminal illness is confirmed, and curative treatments are no longer effective, typically within six months. Similarly, the National Health Service (NHS, UK), along with the National Institute for Health and Care Excellence (NICE) guidelines on EOLC, recognizes a timeframe of 12 months or less.[18] The Indian Council of Medical Research (ICMR) policy document (2018) also emphasizes the vital importance of providing compassionate, patient-centered EOLC, without pinpointing an exact timeframe.[19] The position statement by ISCCM/IAPC recognizes terminal illnesses as those in which death is expected in the foreseeable future, usually 12 months or less.[20]

The Supreme Court judgment, ICMR, and ISCCM/IAPC Expert consensus guidelines provide clear guidance for hospital administrators and caring physicians when approaching end-of-life decisions.[21] The legal acceptance of a Living will (AMD) typically provides specific instructions for treatment limitation (e.g., refusing life-sustaining treatments such as ventilator support or cardiopulmonary resuscitation). This can include a patient's clear decision to refuse resuscitation, such as a do not attempt resuscitation (DNAR) order, or to refuse intubation, such as a do not intubate (DNI) order, highlighting the importance of respecting individual autonomy and dignity in EOLC.

THE MODERN PROCEDURAL ARCHITECTURE FOR END-OF-LIFE CARE

The spectrum of treatment limitation in terminal illnesses, advanced cancers, or permanent severe neurological states, such as persistent vegetative

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TABLE 1: The two-tier hospital medical board protocol.

Component	*Primary medical board (PMB)*	*Secondary medical board (SMB)*
Composition	Three medical professionals, typically including the admitting physician, the treating intensivist/ anesthesiologist, and a relevant specialty expert	Three independent medical professionals, including one external expert nominated or empaneled by the District Chief Medical Officer (CMO)
Experience	All members must possess a minimum of *5 years* of standing in their respective specialties	All members must possess a minimum of 5 years of experience
Mandate	Performs the initial physical assessment, reviews treatment futility, and forms a preliminary opinion	Performs an independent clinical verification of the patient's medical condition to concur or dissent with the PMB
Timeline	Must be initiated and completed without undue delay once treatment futility is recognized	Must provide its definitive clinical opinion preferably within *48 hours* of case referral

states (PVS), Minimally Conscious States (MCS), ranges from withholding life-sustaining treatment (WH-LST), nonescalation, deescalation to WD-LST. Whereas WH-LST refers to non-initiation or non-escalation of LST following refusal by a patient of sound mind, or by prior AMD or Shared decision with family/surrogate, WD-LST entails stopping or interrupting LST without substituting an alternative intervention. Though morally and ethically these terms are not synonymous, they are considered equivocal in legal terms. To safely execute an end-of-life directive or initiate WH/WD-LST under the current legal landscape, anesthesiologists and critical care physicians must navigate a simplified two-tier hospital medical board protocol **(Table 1)**.

The updated ISCCM/IAPC joint position statement elaborates on the procedural framework for end-of-life and palliative care within advanced care planning (ACP) clinical pathways, guided by the Supreme Court judgment and the ICMR policy[21] **(Table 2)**. This guidance emphasizes the central role of an intensivist who recognizes the triggers for EOLC, convenes multidisciplinary meetings, discusses goals of care with the family to support shared decision-making, and keeps ethical, existential, spiritual, cultural, and legal considerations at the forefront. The intensivist ensures the guiding principles of autonomy, beneficence, nonmaleficence, and distributive justice while emphasizing transparent, empathetic family communication **(Flowchart 1)**.

A more practical framework for a 12-step process of ACP, ensuring patient-centered, ethical, and transparent EOLC, tailored to India's legal,

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TABLE 2: Essential steps and decision points for clinical end-of-life and palliative care pathway.[1,21]

Step	*Key actions*
Physician: Prognostic Assessment	Identification of patients with terminal illness/poor life expectancy, where the burden of medical interventions outweighs the benefits
Primary Medical Board (PMB) Consensus	Multidisciplinary team reviews case reports and confirms appropriateness of EOL care
Multidisciplinary family meetings (MDFM) and shared decision-making	Early sensitive discussions with patient (if capable) and/or LAR (legally acceptable representative)/surrogate to align goals of care and explore preferences
Secondary Medical Board (SMB) review	Independent board reviews and ratifies PMB decision; legal notification to District Judicial Magistrate of the first class (no approval required)
Implementation of withdrawal life-sustaining treatment (WD-LST)	Carry out agreed treatment for WD-LST with a palliative plan in hand
Palliative care and support	Address physical, emotional, and spiritual needs; provide symptom management and bereavement support
Documentation and oversight	Ensure thorough documentation, team debriefing, and institutional oversight and quality control (clinical ethics committee assessment)

Note:

- At any point where there is conflict or disagreement between PMB and SMB, continue to provide full support until the conflict is resolved. Resubmit with a detailed justification for reassessment by SMB. If disagreement persists, approach the hospital's Clinical Ethics Committee or the High Court directly.
- Ensure a 48-hour timeline between PMB and MDFM, and between PMB and SMB for expeditious implementation of the foregoing LST in the patient's "best interests principle"

ethical, and cultural landscape, has been recently proposed by a consensus group of experts in palliative medicine, neurology, critical care, and geriatrics, supported by key medical organizations.[22] This proposed pathway plans ACP over three dynamic phases of creating living wills, conducting periodic medicolegal reviews and updates, and executing AMDs.

Do Not Resuscitate/Do Not Attempt Resuscitation Orders

Do not resuscitate or "DNAR" orders are medical directives, issued by a patient or their authorized surrogate, to medical professionals to withhold cardiopulmonary resuscitation (CPR) in the event of cardiac or respiratory arrest. Patients who are unlikely to benefit from resuscitation are considered

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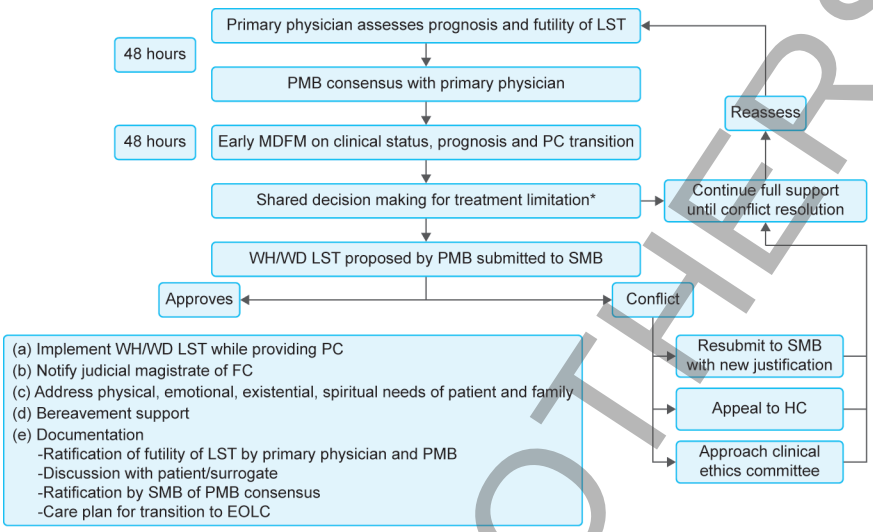
Flowchart 1: Pathway for transition to end-of-life care and palliative care.[1]



(AMD: advance medical directive; EOLC: end-of-life care; FC: first class; FLST: foregoing of life-sustaining treatment; JMFC: judicial magistrate of first class; LST: life-sustaining treatment; MDFM: multidisciplinary family meeting; PC: palliative care; PMB: primary medical board; SDM: shared decision-making; SMB: secondary medical board; WD: withdrawal; WH: withholding)

*Discuss goals of care for respiratory support (Oxygen, noninvasive ventilation, DNI, and invasive ventilation); Cardiovascular support (vasopressors, intravenous fluids, pacemaker, etc.)

candidates for DNAR orders, emphasizing the importance of respecting patient dignity and avoiding unnecessary interventions. The ICMR Consensus Guidelines on DNAR defines DNAR as a decision not to initiate or perform CPR, based on terminal illness, where the patient's chances of surviving in the event that he/she needs CPR are extremely low, and the patient is fully aware of his/her terminal illness, or, if the patient is incompetent, a surrogate on behalf of the patient decides not to perform CPR.[23] It further defines the Do Not Intubate (DNI) order whereby an endpoint for aggressive support is placed up to noninvasive ventilation or high-flow nasal device instead of endotracheal intubation. This landmark guidance finally provides a formal framework for addressing a critical, long-standing dilemma faced by Indian physicians, underscoring India's commitment to ethical medical practices and compassionate EOLC.

Legal Validity of Do Not Attempt Resuscitation Orders

Previously, DNAR lacked official recognition in India, despite its widespread international practice and clear legal backing. The ICMR expert consensus

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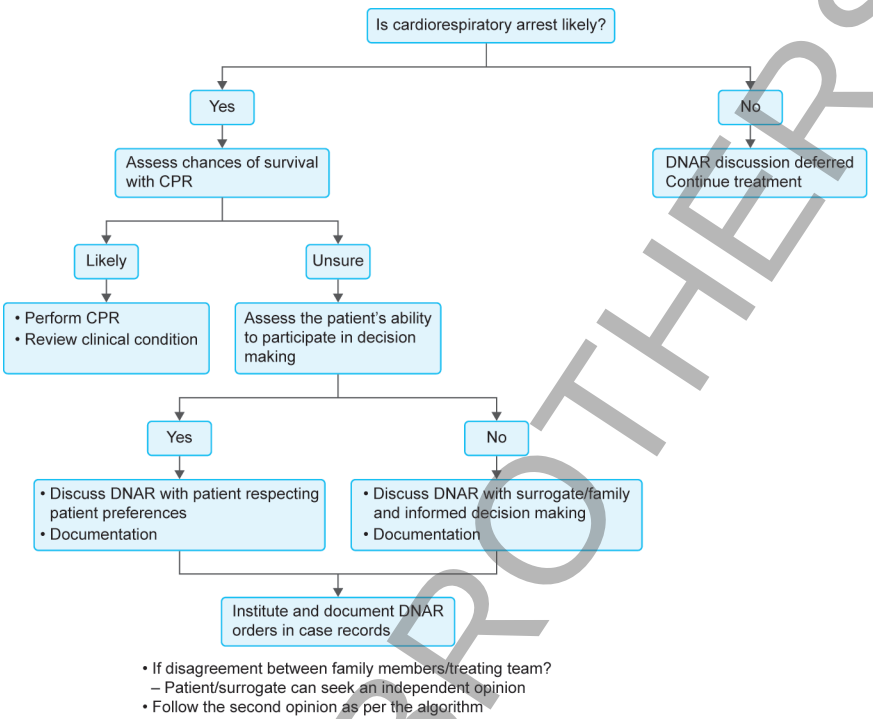
Flowchart 2: Simplified pathway to implement do not attempt resuscitation (DNAR).[19]



(CPR: cardiopulmonary resuscitation; DNAR: do not attempt resuscitation)

introduced a standardized DNAR form and a patient proforma sheet for hospitals to integrate into their policy, ensuring uniform documentation and minimizing ambiguity.[19] These guidelines clearly define the roles of the physician and surrogate decision-makers, while emphasizing shared decision-making, clear communication, and maintenance of patient dignity **(Flowchart 2)**.

It is noteworthy that a DNAR only pertains to resuscitation efforts. Even with DNAR orders in place, a healthcare worker is committed to offering essential support to comfort and ease suffering. This entails continuing full support except for cardiopulmonary resuscitation; all interventions other than CPR are continued, i.e., clearing the airway, providing oxygen, positioning the patient for comfort, splinting injuries, controlling bleeding, administering pain relief and sedation, offering emotional and spiritual support, and contacting hospice or hospital services. Simplistically, a DNAR directive mandates that healthcare providers are not required to perform chest compressions, insert advanced airways, administer cardiac resuscitation drugs, provide ventilator assistance—including noninvasive ventilation—or deliver defibrillation, which could significantly impact patient care decisions. Often, this order is included in an advance directive, such as a living will,

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thereby granting legal immunity to the treating physician and the hospital, or is agreed upon by the family/surrogate in the absence of an AMD. Similarly, DNI orders place a ceiling on respiratory support, limiting it to noninvasive ventilation or high-flow devices rather than an advanced airway.

End of Life Care in Brain-Dead Patients

An overlooked area in the evolving end-of-life practices is the critical care setting, where intensive care physicians grapple with the medicolegal dilemma of whether to continue treatment for brain-dead patients.[24] The Transplantation of Human Organs Act (THOA) 1994 explicitly acknowledges brainstem death in organ donation cases. This presents a significant challenge for doctors who cannot certify brain death if the family refuses organ donation, while the ethical and financial pressures of ongoing care threaten to erode trust. Such situations not only undermine dignity at death but also create suspicion and mistrust among families, who may see doctors as engaging in financial extortion by prolonging futile treatments. The joint position statement by ISCCM and IAPC has marked a substantial advancement, moving away from the traditional tendency for aggressive interventions and resuscitation, and toward a broader recognition of patient autonomy—evidenced by the adoption of EOLC pathways and DNAR orders.[21,25,26] A major roadblock in brain-dead patients is the nonuniformity of the definition of death as per the Bhartiya Nyaya Sanhita (BNS), 2023; the Registration of Births and Deaths (RBD) Act, 1969; and the Transplantation of Human Organs and Tissues Act (THOTA), 2011. Whereas BNS and RBD legislation define death as irreversible cessation of all forms of life, primarily for administrative purposes, distancing from brain stem death and cardiopulmonary death, THOTA defines brain stem death certification solely in the context of organ donation.[27] Once certified, maintenance of organ function till organ harvest, followed by withdrawal of life support, is legally and ethically permissible without waiting for cardiac arrest.

The dilemma for treating physicians lies in the maintenance of a brain-dead nondonor patient, whereby conflicting moral, ethical, and legal issues intersect with patient dignity in death. Perhaps the ISCCM/IAPC guidance on EOLC is the current approach, but it violates the best interests' principle and patient dignity at the near end of life because of the time frames it would need to be met for LST withdrawal. Nonetheless, multidisciplinary family meetings and shared decision-making must involve clear, compassionate communication among the primary medical team, palliative care specialists, and the patient's family.

What may currently appear as a slippery slope could actually be the pathway forward, achieved through the adoption of clear, formal "DNR" legislation and a consistent definition of death in nondonor brain death

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cases. Embracing these measures ensures ethical clarity and social trust in end-of-life decisions. Though a few states, such as Kerala, Tamil Nadu, and Gujarat, have administrative orders on brainstem death as death certification and future recourse for such patients, there is a felt need to bridge this gap and establish uniform definitions across the country,[27] along the lines of Uniform Determination of Death Act (UDDA) for Brain death/Death by Neurologic Criteria (BD/DNC) as in the United States of America.[28,29] Doing so, will safeguard the interests of both the public and the medical community, ensuring ethical clarity, preserving dignity, and restoring faith in healthcare.[30]

Legal Frameworks and Challenges of AMDs: A Comparative Analysis

The Supreme Court of India, upholding the personal autonomy of individuals and balancing the duty of care of medical professionals, allowed AMDs in *Common Cause versus Union of India*.[3] Though the judgment does not explicitly mention DNAR orders, the advance directives may include the same; however, the directives must be provided by terminally ill persons who are competent and of sound mind. The judgment of *Common Cause* grants protection to medical professionals who, under bona fide circumstances, withhold any life-sustaining measures.

Nonetheless, the validity of an AMD/DNAR can encounter several roadblocks. The procedure for validating advance directives in *Common Cause versus Union of India* was complex. These were later clarified by the Supreme Court in 2023.[10] However, no explicit regulations have been made by the erstwhile Medical Council of India (now National Medical Commission) recognizing advance directives or DNR orders. Several medical institutions and a few states have developed their own internal guidelines, based on ICMR guidance on DNAR, to ensure that the patient's autonomy and dignity are respected.[31] The ICMR guidelines require medical professionals to inform and discuss the possibility of cardiac arrest with patients who are undergoing cardiorespiratory issues.[19] However, the effect of these guidelines, in the absence of comprehensive legislation, and the emphasis on CPR as a necessary measure, create a hurdle to the smooth implementation of DNAR orders.[32]

In contrast to India, the United States has held the patient's decisional autonomy as paramount. The Patient Self-Determination Act of 1990, read in consonance with the Social Security Act, was enacted with the view to ensure the participation and direction of patients in their own medical treatments. This includes the right to refuse any treatment and the right to execute any valid advance directives issued by the patients.[33] The Act further creates a positive obligation on medical institutions providing care to formulate policies and to inform patients of their rights regarding participation in their

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medical treatment. Similarly, in the United Kingdom, the Mental Capacity Act 2005 formulates that a person with capacity who is 18 years of age may issue advance directives that a specific treatment must not be carried out. The Act, specifies that medical professionals are granted protection from liability if they continue any treatment, provided they are satisfied that the advance directives are valid. The Canadian Charter of Rights and Freedoms grants the rights to life, liberty, and security of the person. The right to refuse treatment has been read as part of the right to liberty by the Canadian Supreme Court, which has interpreted it as the right to make reasonable medical choices.

Although recent cases such as Harish Rana versus Union of India and Common Cause versus Union of India have affirmed the enforceability of advance directives in India, the absence of explicit laws recognizing DNAR orders underscores a critical legal gap that warrants urgent attention.

LEGISLATIVE VACUUM AND ONGOING CHALLENGES

Despite the Supreme Court's repeated urges to the Parliament to enact comprehensive legislation on euthanasia, the Parliament has been slow to respond. The Law Commission of India, in its 196th Report titled "Medical Treatment of Terminally ill Patients," recommended legislation for EOLC. However, the report expressed skepticism regarding advanced directives, cautioning against potential misuse by family members and medical professionals.[16] The Supreme Court's decision in *Common Cause* reiterated the need for updated legislation that addresses the withdrawal of life support and advanced directives, striking a balance between autonomy and the duty of care to sustain life. However, the legislature did not heed the Court's appeal to create such a framework. The closest action taken to any legislative formulation has been the draft Medical Treatment of Terminally-ill Patients (Protection of Patients and Medical Practitioners) Bill, 2016. The Bill faced criticism for having imprecise and contradictory provisions and for failing to interact with the Mental Health Act, 2005. The Bill further did not grant validity to AMDs or medical Powers of Attorney.[34] This Bill, however, was not further tabled before the Parliament. No other legislative attempt has been made to address passive euthanasia in India.

This is why, despite its progressive character, Indian jurisprudence on the constitutional regulation of life and death does not resolve every concern. For instance, the absence of comprehensive legislation continues to create uncertainty.[35] End-of-life decisions in India remain governed largely by judicial pronouncements rather than statutory enactments. Further, questions regarding implementation in resource-constrained healthcare settings also remain unresolved because access to specialist medical boards,

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ethics committees, and palliative care facilities varies significantly across the country.

There are also legitimate concerns regarding potential misuse, particularly in situations involving vulnerable patients, inheritance disputes, or economic pressures.[36] This is why the extensive safeguards and transparent procedures proposed by the Indian Supreme Court remain indispensable. Additionally, the social and cultural diversity of India means that attitudes towards death, suffering, and withdrawal of treatment may differ substantially across communities.[37] Legal frameworks must remain sensitive to these realities while upholding constitutional values.

CONCLUSION

The term "euthanasia" often evokes moral and emotional controversy. However, modern healthcare increasingly focuses on the broader concept of EOLC. Perhaps the most important contribution of the *Harish Rana* judgment is its emphasis on end-of-life decision-making rather than euthanasia alone. The judgment is not an endorsement of death as a solution. Rather, it is a recognition that there may be circumstances in which continued medical intervention no longer benefits the patient and merely prolongs irreversible incapacity, based on the "best interests" principle. The relevant inquiry is not whether life has value, but whether continued treatment serves the patient's interests. When treatment no longer offers any prospect of recovery and merely prolongs biological existence, withdrawal of such treatment may be consistent with dignity and compassion.

This judgment advances Indian law in several respects. First, it strengthens the recognition of human dignity as a constitutional value by acknowledging that dignity extends to the final stages of life and cannot be divorced from end-of-life decision-making. Second, it provides practical guidance on the WD-LSTs, such as clinically assisted nutrition and hydration, an area that previously remained uncertain. Third, it reduces the likelihood of medically futile treatment that serves no therapeutic purpose. Fourth, it reinforces patient-centered healthcare by emphasizing autonomy, dignity, and best interests rather than purely biological survival. Finally, it contributes to the development of a more humane and compassionate approach towards terminal and irreversible medical conditions.

As India continues to develop its framework for EOLC, the *Harish Rana* judgment is likely to serve as an important reference point for courts, physicians, policymakers, and ethicists alike. It stands as a reminder that dignity is a value that must guide society in confronting the realities of death. However, one must be cautious while depending solely on judicial pronouncements to develop a framework on passive euthanasia in India. ICMR and ISCCM/IAPC have taken a significant step in this direction, guided

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by the Supreme Court judgment, to formulate end-of-care guidance and DNAR orders. It is timely for clinicians and hospital administrators to embrace these guidelines in clinical practice. The Supreme Court further acknowledges in its own decisions that the conception of dignity as a constitutional value, while significant, does not fill the legislative vacuum. The courts, while attempting to balance state paternalism and personal autonomy, cannot address the issues of palliative care and the rights of individuals' wills in treatment beyond a point. Hence, the felt need for legislative discussion and action to provide a framework for euthanasia to persist.

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