THE DIGNITY THE LAW MISSED: TERMINAL PATIENTS, ACTIVE EUTHANASIA AND THE SILENCE OF THE CONSTITUTION

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ABSTRACT

This paper begins with a question that the law has not yet properly answered: what happens to a patient who is terminally ill, fully conscious, and in daily pain but has no machine to switch off? In March 2026, the Supreme Court of India permitted passive euthanasia for a real individual for the very first time. The judgment in Harish Rana v. Union of India was a watershed. But it also threw into sharp relief a gap that has existed in Indian constitutional law for decades, the complete absence of any legal protection for dying patients who fall outside the passive euthanasia framework. This paper examines that gap. It is not an argument for unrestricted legalisation of active euthanasia. It is an argument that the Constitution, which has always claimed to protect human dignity, cannot keep pretending that certain dying people simply do not exist.

I. INTRODUCTION

Some questions sound like they should have easy answers. If a person is dying knowingly, painfully, irreversibly and they ask for help ending their suffering, what does the law say? In India, as it currently stands, the answer depends almost entirely on whether a machine is involved. If there is a ventilator, a feeding tube, a device sustaining the patient's life, the law has a process. The family can approach a medical board. A court may intervene. The treatment can, under careful conditions, be withdrawn. The patient dies. The Constitution calls that dignity.

But take the machine away. Put the same patient in the same bed, with the same terminal diagnosis, the same clear mind, the same request except now there is no device keeping them alive. They are simply dying, slowly, on their own, in pain. What does the law say to them?

Right now, it says nothing. There is no framework, no legal pathway, no constitutional conversation that speaks to this patient's situation. They exist in a gap so wide and so quietly maintained that most people who think about euthanasia in India do not even realise it is there.

This paper is about that gap. It asks a question that Harish Rana v. Union of India, the most significant euthanasia judgment in Indian legal history both illuminated and left entirely unanswered: whether Article 21 of the Constitution, the provision that has been stretched across decades to cover privacy, livelihood, reputation, and the right to die with dignity, has anything at all to say to a dying person who needs no machine to stay alive and no machine to stop.

The argument here is not that active euthanasia should be made freely available or that its risks are imaginary. Those risks are real and they deserve serious attention. The argument is narrower: that a blanket constitutional silence on the situation of these patients is neither defensible nor inevitable. That the same logic which took our courts from the textbook meaning of Article 21 to recognising the right to die with dignity in Common Cause v. Union of India, 2018, if followed honestly, demands that the question at least be asked. And that a patient who is awake, suffering, and asking, deserves more from the Constitution than the patient who cannot ask.

II. A LINE THE LAW DREW AND HAS RARELY QUESTIONED

The legal distinction between active and passive euthanasia is, on the surface, straightforward. Passive euthanasia means stopping or not starting a treatment that keeps someone alive. Active euthanasia means doing something like administering a drug or taking a deliberate step that directly ends a life. Indian law permits the former and prohibits the latter. The moral intuition behind this is understandable: letting nature take its course feels different from actively intervening.

But consider what the Supreme Court actually permitted in Harish Rana. The patient was receiving clinically assisted nutrition and hydration through a surgically inserted tube. The Court allowed that tube to be removed. Without it, the patient would stop receiving food and water and would eventually die. The Court knew this. It permitted it anyway rightly so, and with thoughtful reasoning. But if we are being honest with ourselves, the removal of a feeding tube that directly results in death is not a passive act in any straightforward physical sense. It required a decision, a procedure and a deliberate step taken by medical professionals with the

knowledge of what would follow. What made it legally passive was not the nature of the act but the category the Court assigned to it.

This is not a criticism of the Court. The Harish Rana judgment is carefully reasoned and the outcome was just. The point is different: the active-passive line is a legal construction, not a natural one. Courts draw it, and courts can examine where it falls. In 1975, philosopher James Rachel made a version of this argument in a paper that law students have been arguing about ever since that the moral difference between letting someone die and causing their death is far less obvious than our instincts suggest, and that what matters morally is the intent behind the act and the condition of the patient, not the technique.

For the patient who has nothing to withdraw, this construction becomes a wall. The law says: we will help you die only if there is something to stop. If your body is failing entirely on its own, without assistance, we have no category for you. Your suffering does not fit our framework. You will have to keep going. There is something deeply strange about a legal system that offers more protection to the patient who is being kept alive by intervention than to the one who is dying without any. The machine, in Indian euthanasia law, has become the gatekeeper of constitutional dignity. That is worth questioning.

III. HOW THE LAW GOT HERE AND WHAT IT LEFT BEHIND

To understand the gap, you have to understand how the law arrived at where it is. India's engagement with euthanasia as a legal question did not begin in a courtroom debate about doctrine. It began with a woman.

Aruna Shanbaug was a nurse working at KEM Hospital in Mumbai. In 1973, she was assaulted by a ward boy, strangled with a chain, and left with severe brain damage. She survived but never regained consciousness. For thirty-seven years, the hospital staff looked after her. In 2011, a petition was filed before the Supreme Court seeking permission to discontinue her treatment. The Court refused to grant it in that case but used the opportunity to do something more lasting: it recognised, for the first time, that passive euthanasia could be permissible in India. It set out conditions. It required High Court oversight. It was cautious to the point of being restrictive, but the door had been opened.

Seven years later, Common Cause v. Union of India took that open door and turned it

into a proper entrance. A five-judge Constitution Bench confirmed that the right to die with dignity is a fundamental right under Article 21. It held that a person could execute an advance medical directive i.e., a living will stating their wishes about end-of-life care before they lost the capacity to communicate those wishes. The procedural framework was restructured, moving away from case by case High Court oversight toward a system of medical boards operating at institutional and district levels. The judgment was long, philosophically rich, and constitutionally significant.

Then came Harish Rana in 2026. A family had spent thirteen years watching a young man remain in permanent vegetative state after accidental fall. They invoked the Common Cause framework. Two medical boards were constituted. The Supreme Court reviewed the record. It concluded that continued life sustaining treatment was no longer in the patient's best interests and permitted its withdrawal. Thirteen years of advocacy, distilled into a judgment of over two hundred and eighty pages. The first real case. The first real answer.

Now look at that entire arc. Aruna Shanbaug, Common Cause, the 2023 procedural modifications, Harish Rana. Every single step has been taken in the same direction. Every judgment, every framework, every procedural refinement has been designed for one type of patient: the patient in a vegetative state, unconscious and unresponsive, sustained by devices that are keeping them biologically alive. The dignity these judgments protect is entirely valid. But the framework that protects it has never once turned its head toward the patient who is awake, terminal, suffering, and waiting for a law that has not yet come.

IV. THE PATIENT, THE FRAMEWORK FORGOT

Imagine a man, fifty-eight years old. He was diagnosed with amyotrophic lateral sclerosis two years ago. He knows what the disease does. He has watched it do it. His hands stopped working first. Then walking became impossible. Now swallowing is difficult. He breathes on his own, for now. His mind is as sharp as it has ever been. He reads. He thinks. He knows, with complete medical certainty, that there is no treatment that will reverse or even pause what is happening to him. He has told his doctors, his family, and anyone who will listen that when the suffering becomes unbearable he wants it to stop. Not to be managed, not to be palliated but to stop.

He cannot use the Harish Rana framework. He is not in a vegetative state. He is not on

life support. There is no treatment to withdraw because no treatment exists that addresses his condition. He has no advance directive that can help him, those directives apply to the withdrawal of medical intervention, and there is nothing to intervene with. The Common Cause framework simply does not speak to his situation. And active euthanasia is the only legal concept that could help him but it is prohibited absolutely, with no framework to evaluate it, no procedure to invoke and no constitutional analysis that has ever seriously considered whether the prohibition can be applied to someone like him.

This is not an invented hypothetical. Conditions like ALS, late-stage pancreatic cancer, end-stage renal failure, advanced Huntington's disease these are illnesses that destroy people slowly and consciously. The person experiencing them is present throughout. They experience every day of it. And in India, where the government's own data has consistently shown the inadequacy of palliative care infrastructure especially in tier-two cities and rural areas, the suffering of terminal patients who cannot access proper pain management is not a rare edge case. It is ordinary.

The Delhi High Court, when it first rejected the petition in Harish Rana, stated plainly that since the patient was not on a ventilator, the withdrawal of nutrition would amount to starvation rather than passive euthanasia. The Court was working within the existing framework as it had no other tool. But read that reasoning from the patient's perspective. You are dying. You cannot invoke your constitutional right to dignity because the manner of your dying does not involve a specific piece of hospital equipment. The Constitution protects the patient in the ICU but not the patient in the general ward. It protects the unconscious but not the conscious. It protects the person who cannot speak but not the person who is speaking, clearly and repeatedly, and getting no answer.

That outcome deserves to make us uncomfortable. Not because the courts have failed anyone deliberately. They have worked carefully within the frameworks they were given. But frameworks are only as wide as the questions that built them. And the questions that built India's euthanasia jurisprudence have always pointed in one direction: toward the unconscious patient, toward the machine, away from the person sitting upright in a hospital bed, which is coherent enough to ask and suffering enough to mean it. That patient has never had their case argued before a court. Not because their situation is legally uninteresting, it is constitutionally urgent, but because no one has yet decided it is worth arguing. That silence in the courtroom is

not proof that the law is settled. It is proof that the law has not yet been challenged where it is weakest. And that is precisely where legal scholarship has something to do.

V. WHAT THE CONSTITUTION HAS NOT YET BEEN ASKED TO DO

Article 21 says that no person shall be deprived of their life or personal liberty except according to procedure established by law. That is all it says, in its text. What it means, after seventy-five years of interpretation, is considerably more.

The Supreme Court in Maneka Gandhi v. Union of India established that the procedure referred to in Article 21 must be fair, just, reasonable and not arbitrary. Francis Coralie Mullin v. Administrator, Union Territory of Delhi expanded the right to life beyond mere survival, holding that it encompasses the right to live with basic human dignity. K.S. Puttaswamy v. Union of India, the nine-judge privacy judgment, confirmed that personal autonomy and the right to make decisions about one's own body are fundamental aspects of the right to life. Common Cause itself drew on all of this to find the right to die with dignity within Article 21.

The logical structure of these decisions, taken together, points toward a conclusion the courts have not yet been asked to reach. If Article 21 protects dignity, and dignity includes the autonomy to decide what happens to your own body, and that autonomy extends as Common Cause case held that to decisions about how one's life ends, then it is very difficult to explain why that protection is available only to patients on life support. The Constitution does not say 'the right to die with dignity applies unless you are dying without intervention.' No judgment has held that. The limitation exists because the right cases have not yet come, not because the Constitution requires it.

The strongest arguments against this position are the risks of misuse: a vulnerable patient pressured by a family that finds caregiving burdensome, a doctor who misjudges the terminal nature of a condition, a social environment in which the elderly and disabled already face structural marginalisation that makes genuine free consent difficult to verify. These concerns are not manufactured. They are exactly the reasons why countries that have travelled this road have done so carefully, slowly, and with extensive procedural safeguards.

But safeguards are the answer to these concerns, not silence. When the Supreme Court first considered passive euthanasia, the same concerns existed, the same fear about misuse, the

same questions about verifying consent. The Court's answer was to build a framework rigorous enough to minimise those risks while recognising the underlying right. Medical boards, judicial oversight, time-bound reviews, requirements for independent medical opinion none of these were impossible to design. They were designed. They exist. The question is whether the same legislative and judicial energy can be directed toward a category of patients who need it just as badly.

The proportionality standard, which the Supreme Court has affirmed as the test for restrictions on fundamental rights, requires that any limitation on a right must pursue a legitimate aim, must be rationally connected to that aim, and must be the least restrictive means available. A complete prohibition on active euthanasia, with no framework, no category, no procedure, and no constitutional engagement, does not self-evidently pass that test, at least not for a terminally ill, competent adult who is explicitly requesting it. That test has never been applied here. Asking for it to be applied is not a radical demand. It is the ordinary operation of constitutional law.

VI. WHAT THE WORLD TRIED AND TAUGHT US

The comparative material here is not offered as a model to copy. India's constitutional structure, its healthcare realities, and its social context are different enough from the Netherlands or Canada that direct transplantation of their frameworks would be both legally inappropriate and practically dangerous. What the comparative experience offers is something simpler: proof that a principled, safeguarded framework for assisted dying is achievable, and that the misuse concerns, while real, are manageable through careful design.

The Netherlands legalised active euthanasia in 2002. The conditions are strict, the patient must be experiencing unbearable suffering with no realistic prospect of improvement, the request must be voluntary, considered, and persistent, and at least two independent physicians must be involved. Mistakes have occurred and been prosecuted. The system has not collapsed. It has been reviewed, adjusted, and continued.

In Canada, the Supreme Court in Carter v. Canada struck down the criminal prohibition on assisted dying as inconsistent with the Canadian Charter of Rights and Freedoms specifically the Charter's protections of life, liberty, and security of the person, which map reasonably closely onto Article 21's terrain. The Court held that the absolute prohibition was

overbroad and failed the proportionality standard precisely because it swept in patients for whom there was no state interest sufficient to override their autonomy. The Canadian Parliament subsequently legislated a framework for medical assistance in dying, which has been revised twice since then as courts and legislators have worked through the harder edge cases.

The point is not that India should follow Canada's path. It is that the argument 'we cannot go there because it is too dangerous' has been tested elsewhere and found to be only partially true. It is dangerous without safeguards. With them, it is difficult but manageable. The danger is an argument for caution in design, not for permanent silence on the question.

VII. CONCLUSION

The man with ALS is still in his room. The woman with terminal cancer is still in her bed. The law is still not talking to either of them.

Harish Rana was a real victory. A family's thirteen-year fight was recognised. A young man whose life had been reduced to the mechanical rhythm of a feeding tube was allowed to leave with some measure of peace. That matters deeply and should not be diminished. But the judgment arrived with a shape and the shape it has, the framework it depends on, the reasoning it uses all of it faces one way. Toward the unconscious patient. Toward the machine. Away from the person who is awake and asking.

There is something worth sitting with in that fact. The right to die with dignity, as Indian law has developed it, has always been claimed on behalf of patients who could not claim it for themselves. The families spoke. The lawyers argued. The courts decided. The patient, in every case, was absent from the conversation about their own death in the most literal sense possible. And now, when the patient is present, when they are conscious and coherent and telling us exactly what they want, the law's response is to have no response at all.

This paper has not argued that active euthanasia should be legalised tomorrow or without serious safeguards. It has argued something much harder to dismiss: that the Constitution's silence on this category of patients is not neutral. Silence is a choice. It has consequences. The terminally ill patient without life support experiences those consequences in the most personal way imaginable, every day that the law continues to look past them.

Article 21 has been expansive enough to cover the right to sleep on a pavement, the right to education, the right to a pollution-free environment. It has covered the prisoner, the undertrial, the patient in a vegetative state. The question this paper ends on is a simple one: whether it is also expansive enough to cover a dying person who is awake, suffering, and asking. Not demanding legalisation. Not asking to circumvent any safeguard. Just asking whether the Constitution has something to say.

If the answer is still no, the law should at least have the honesty to say so plainly and to explain why the dignity of this patient counts for less than the dignity of every other patient the Constitution has found room to protect. That explanation, as far as this paper can determine, does not yet exist.

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