JOURNAL OF INTERNATIONAL RESEARCH & MULTIDISCIPLINARY INNOVATION

E-ISSN: 3139-8650

Volume: 2 Issue: 2 Month: September 2026

From Patient Autonomy to Patient Best Interests: The Changing Architecture of End-of-Life Decision-Making in India

A Doctrinal and Critical Analysis of the Jurisprudence from Gian Kaur (1996) to Harish Rana (2026)

Author: Ratna Upadhyay

Affiliation: Mahatma Gandhi Kashi Vidyapeeth, Varanasi

Email: ratna105607@gmail.com

Submitted to: Journal of International Research & Multidisciplinary Innovation (JIRMI)

Date: 05 September 2026

Abstract

This paper explores how the process of deciding on terminating treatment has changed in India from the time of a regime in which each such choice required judicial permission, to the time of a regime where the individual's autonomy has been enshrined in the constitution by the formulation of Advance Medical Directives, which is now being succeeded by a regime where the best interests of the patient is the sole basis on which treatment is decided, to be determined by medical boards, the family and, if necessary, the Supreme Court. The paper traces the line of authority from Gian Kaur v State of Punjab (1996) to Harish Rana v Union of India (2026), and follows the trajectory of the case along with the Draft Guidelines issued by the Ministry of Health and Family Welfare in September 2024 and the empirical evidence of accessibility of palliative care. It states that the journey from autonomy to best interests is not a straightforward one, and that it does not represent the rejection of autonomy. It is more commonly recognized as a restructuring of the legal system that arose in response to the ineffectiveness of directive autonomy as a practical solution and the increasing number of patients who did not make a directive. Structural weaknesses identified in the current architecture include the indeterminacy of the best-interests standard, the centralization of decision-making power in institutional decision makers and palliative care infrastructure

deficiencies and the paper suggests that the only long-term solution is statutory codification.

Keywords: *passive euthanasia; Advance Medical Directive; best interests; substituted judgment; Article 21; clinically assisted nutrition and hydration; palliative care; India*

1. Introduction

The withholding and withdrawal of life-sustaining treatment is a junction where constitutional rights, clinical judgment and family responsibility converge. Indian law took a long time to reach this point and did so in an adjudicative rather than legislative fashion. There is no general law on the withdrawal of treatment from patients who are terminally ill or permanently unconscious so far and all the law in force is based on the decisions of the Supreme Court of India, who have used the power conferred on it by Article 142 of the constitution to make up for the absence of a law.

That basic tenet of that system has changed in 30 years. The initial question that was raised by the Court was that if the law could tolerate the patient's withdrawal from the treatment or not, and the Court answered to the High Courts in its first phase. In the second phase of the Constitution Bench in Common Cause v Union of India (2018), the Court found the right to refuse treatment included within the right to life and personal liberty under Article 21 and established the Advance Medical Directive (AMD) (the living will) as the primary means by which a person would be able to make this decision prior to their becoming incapable. [3] In its third and latest phase of Harish Rana v Union of India (2026), the Court used the principles of the 2018 order, as amended in 2023, and determined the issue from the standpoint of the patient who did not leave any instructions.

The question here is whether, and how, the Indian position has shifted from patient autonomy to patient best interests, and what institutional implications follow. The paper makes three propositions. First, this is not a shift from one standard to another, but rather a change of emphasis in a multi-layered standard: where a valid direction exists, autonomy is the preferred standard; and where there is no valid direction, the best interests is the prevailing standard. Second, it's been a gradual shift because the directive approach has empirically failed to actually reach the population it intended to reach. Third, the shifting of best interests as a standard from the individual to institutionalized standards further gives power to institutions

which will determine the meaning of the procedural safeguards and the availability of palliative care, and hence the legitimacy of the framework.

The question is important both in the doctrinal and practical sense. It's doctrinally, a test of a constitutional system without a statute on the matter to give rise to a consistent set of decisional standards through the process of adjudication alone, and it requires a reconciliation of three lines of reasoning that developed over time and on different premises, so that of Gian Kaur on the natural process of dying, the guardianship-based approach of Shanbaug, and the rights-based approach of Common Cause. In practice, this question is relevant for a lot of growing and large families and clinicians. With chronic and non-communicable disease and advances in critical care, a larger number of patients can now be maintained for extended periods of time in states of severe and irreversible impairment, and the legal rules that address when and how treatment is able to be limited guide the daily activities of hospitals.

The paper goes on to discuss the following. The methodology and the limitations of the study are presented in Section 2. Section 3 outlines the theory for analysis of the case law. From 1996 to 2026 doctrinal development is covered in Section 4. Executive and State-level instruments are explored in Section 5. Section 6 provides an analysis of the structure of the framework, of the autonomy deficit, of the indeterminacy of the best-interests standard, of the centralisation of institutional powers, of the treatment of artificial nutrition, of the role of palliative care, of equity, of professional liability and of the constitutional validity of judge-made regulation. Recommendations are detailed in Section 7, limitations and future research directions are suggested in Section 8, and Section 9 concludes.

2. Methodology and Scope

The study is of a doctrinal nature. It proactively reviews the main decisions of the Supreme Court, executive directives from the Ministry of Health and Family Welfare and existing empirical evidence regarding the provision of palliative care. The reference list contains only seven key and scholarly sources that were deemed to be authoritative and directly relevant; other documents such as the Mental Healthcare Act 2017, and a circular issued by the State, are mentioned and cited in the text by name and year, and are not listed separately. The interpretation of Harish Rana is based on the text reported in this judgment, and on the

neutral citation 2026 INSC 222, paragraph-level citations must be checked against the certified copy of the judgment before the paper is submitted for publication. Apart from active euthanasia and assisted suicide which are still illegal in India, and are only mentioned if required in order to explain the limit of the permitted category, the paper does not deal with these. Comparative material is used sparingly, and is only used to further explain the conceptual content of the best interest's standard.

3. Conceptual Framework: Autonomy, Substituted Judgment and Best Interests

Three decisional standards organise the literature on treatment withdrawal. The autonomy standard provides implementation for the competent patient's concurrent refusal, or, if one had existed, the prior refusal in a valid directive, based on the principle that a person has the right to refuse treatment even if such refusal can lead to death of the patient. The substituted judgment standard requires a surrogate to make a determination as the patient would make, basing it on what the patient has previously said, on the patient's character and conduct. The best interest's standard requires the decision-maker to think objectively about what is in the patient's best interests; this does not mean that they have to be the same interests that are held by the patient, but rather that they have to be in the patient's best interest; it is normally used when reliable evidence of the patient's wishes is not available.

Another differentiation is setting up the ethical discussion. Withholding or withdrawing treatment is considered passive euthanasia, while giving a lethal agent is considered active euthanasia. The former has been consistently upheld by the Indian Courts as permissible within certain boundaries while the latter has been consistently held by the Indian Courts as impermissible unless legislated. This jurisdiction's best-interests standard, motivated by the reasoning in Airedale NHS Trust v Bland [1993] AC 789, as used in Indian decisions, is an investigation into whether continued treatment is in the interests of the patient and not his death. The difference is important because it shifts the moral focus of the question from ending of life to the justification for the artificial extension of life, as the Supreme Court did explicitly in 2026.

3.1 Autonomy and consent

In Indian constitutional law the autonomy standard derives its authority from the recognition that the right to bodily integrity, privacy and personal liberty is part of the protection afforded under Article 21. The refusal to receive medical treatment was interpreted by the Constitution Bench in Common Cause as an exercise of that sphere and extended to in advance of 'incapacity' by an AMD. There is a corollary of the principle in normal medical practice: treatment that is not consented to is a wrong, and a competent adult can refuse treatment which a clinician considers to be beneficial. The temporal distance of the end-of-life setting is that by the time it is time to make the decision, the person whose wishes are to be honoured cannot confirm or revise them. A directive written several years ago presents interpretive issues, because actual events may be very different from those the author was thinking about when writing it, and authentic issues, because it is impossible to establish whether the author had a similar attitude at the time they were rendered incapacitated. Indian guidelines contain the procedural safeguards that can be interpreted as answers to these two issues.

3.2 Substituted judgment

If the person has not made a directive but has communicated his or her wishes to family members or made his or her wishes known from a consistent set of values, a surrogate may be asked to make the decision on behalf of the person. The standard is still linked to autonomy as it tries to cater to the patient's choice, but its evidentiary basis is rather flimsy, relying on memory and assumption from involved parties. The Indian decisions fail to be consistent in labeling the standard. The Court in Harish Rana followed the reasoning of a Court in which the parents' and the medical boards' perspectives converge on what is in the patient's best interests, and, in this reasoning, the family's perspective is relevant to the best interest's determination. The dichotomy between substituted judgment and best interests is thus fluid in the existing Indian law, which will be discussed again in Section 6.3.

3.3 Best interests, futility and proportionality

The best interests' standard focuses on the patient's welfare, as judged by an objective standard, and is usually associated with two clinical concepts. Medical futility refers to an intervention which cannot have a physiological or therapeutic effect which the patient could value and proportionality refers to balancing the burden of an intervention against its likely benefits. Both theories rely on the clinical prognosis and both rely on making value judgements on what is a benefit. A court or board applying the standard must therefore answer a medical question, of whether the patient is capable of recovery, and a normative question, of whether it is a benefit to the patient to continue to live in this condition. The formulation of the Supreme Court in 2026 is: Is continued treatment in the patient's interests? This restricts the inquiry to justifying treatment, but not a direct assessment of the value of the patient's life. Whether that suffocation is feasible in practice, because the answer to the question of benefit will often depend on a tacit evaluation of the patient's life will be explored in Section 6.3.

4. The Doctrinal Evolution

4.1 Gian Kaur and the foundations of the right

The constitutional starting point is *Gian Kaur v State of Punjab* (1996), in which a Constitution Bench overruled *P. Rathinam v Union of India* (1994) and held that the right to life under Article 21 does not include a right to die, so that Sections 306 and 309 of the Indian Penal Code were constitutionally valid. The decision is usually cited against any right to die. Its significance for present purposes lies in an observation that distinguished the unnatural extinction of life from the natural process of dying, and that contemplated the right to live with dignity as extending, in the case of a terminally ill or persistently vegetative patient, to a dignified conclusion of the natural process. This distinction, between hastening death by an act and permitting death by omission, supplied the conceptual space in which every subsequent decision operates.

4.2 Aruna Shanbaug and judicial supervision

In Aruna Ramchandra Shanbaug v Union of India (2011), the Court discussed a petition filed by family members of a nurse who had been in a persistent vegetative state at the KEM Hospital in Mumbai since 1973 when he had been assaulted. The petition filed by a journalist

as next friend was dismissed on 7 March 2011, mainly on the ground that the hospital staff who had cared for the patient for decades were her appropriate surrogate parties and didn't move for withdrawal. The Court did however decide that in India the passive form of euthanasia was acceptable and went on to suggest that until legislation was introduced a decision to withdraw life support must be made by the High Court as the parens patriae based on the opinion of a committee of three doctors. There are two aspects of the decision that are worth reiterating. The standard it applied was of the best interests of the patient, as the patient was incapable of giving any views. And its process made the High Court the hub of all cases, which in turn proved to be impractical because there were not that many families who could litigate for months with a member of the family in intensive care. In 2014, a three-judge bench, noting that the reasoning in Shanbaug was "inconsistent" since it was based on a lack of legislation but itself provided guidelines, sent the matter back to a Constitution Bench. Ms Shanbaug passed away in May 2015.

4.3 Common Cause (2018): the constitutionalisation of autonomy

The judgement was rendered on 9 March 2018 by the Constitution Bench in the case Common Cause v Union of India, which relied on four concurring opinions, concluding that the right to die with dignity is an integral component of the right to life guaranteed by Article 21 of the Indian Constitution and that the right to refuse medical treatment is an incident of autonomy, privacy and bodily integrity. The Court confirmed passive euthanasia and the status of AMDs, and, in the exercise of its powers under the Article 142, issued guidelines until Parliament passed laws. Those guidelines provided for a written direction, voluntarily made without being compelled by anyone, to be used only when the treatment was to be withheld or withdrawn from a person who was of sound mind could be made by such person, and that such person may nominate a guardian or close relative to make it. The instruction had to be signed in the presence of two witnesses and countersigned by a Judicial Magistrate of First Class (JMFC). A hospital medical board was to review the case on the patient's loss of capacity, a second board, made up of the Collector was to review, and the JMFC was to visit the patient before the decision took effect. Patients who had not directed an application were treated by parallel guidelines, where the application was made by the family or treating physician, and the same layered scrutiny used.

The ruling is significant because of its emphasis on "personal choice. It was also a period of prudence, however. In the first place the guidelines were meant to protect against abuse, and they mandated that the case be certified by boards consisting of experienced senior practitioners in the specialty in question and be verified by a magistrate. The design was based on the assumption that the most likely threat was early or forced exit, and adjustments were made to safeguards accordingly.

4.4 The order of 24 January 2023: procedural recalibration

In less than 5 years, it was clear that the procedure of 2018 was not being used. The Indian Society of Critical Care Medicine had asked for clarification and modification; and, during the hearings, counsel for Common Cause (CCM) revealed to the Bench that no case was witnessed in which an AMD has been given effect whatsoever since the 2018 judgment. On 24 January 2023 a Constitution Bench accepted a joint proposal of the Union and the Society and relaxed the guidelines. The following were the main changes. The notarial attestation or gazetted officer was substituted instead of attestation by the JMFC. The hospital board was replaced by a Primary Medical Board consisting of the doctor treating the patient and two subject experts having not less than five years' experience instead of twenty years. The Secondary Medical Board consisted of a registered medical practitioner appointed by the Chief Medical Officer of the district and at least two other medical experts not on the Primary Board, replacing the Collector's board. Each board was asked to state its opinion within forty-eight hours and the hospital was not asked to get judicial permission, but only to communicate its opinion to the JMFC. The purpose of the modification was to shift the focus from the courts to the doctors and lay the foundations for the ruling of 2026.

4.5 Harish Rana (2026): best interests in the absence of a directive

In Harish Rana v Union of India, the bench of Pardiwala and Viswanathan JJ had before them a man of thirty-two years, who had been in a permanent vegetative state for some thirteen years after falling ill in 2013, and who had to rely on a clinically assisted nutrition and hydration (CANH) tube, a urinary catheter and a tracheostomy. His parents had filed a petition to constitute a medical board for his withdrawal, but in 2024, the Delhi High Court had allowed

the same, saying the patient not on a ventilator cannot be seen as being starved. Primary and Secondary Medical Boards established during the proceedings reached a consensus that a decision to withdraw CANH was in his best interests and that his condition was irreversible.

The Supreme Court granted the appeal and, in its reasoning, gave three propositions of general importance. First, it was accepted that a feeding tube (with the exception of basic care) constitutes medical treatment and therefore is covered by the Common Cause framework and can be withdrawn or withheld as medical treatment. Secondly, it reaffirmed that the best interest's principle is the principle that governs patients who are not able to make decisions for themselves and that the best interests principle admits of no formula, and that the question to be answered is whether it is in the patient's best interests that his life should be prolonged by continued treatment, and not whether it is in his interests that the patient should die. The considerations were medical futility, irreversible, dignity and the consensus opinion of the next-of-kin and the two boards. Thirdly, the Court reaffirmed that the withdrawal should be accompanied by a structured palliative and end-of-life care plan and it streamlined the procedures for patients to receive care at home. It is the first comprehensive application of the Common Cause framework in order to withdraw life sustaining treatment and will bring together a synthesis of best interests with the reconstruction of the patient's probable wishes.

4.6 The 2018 and 2023 procedures compared

The practical content of the shift between 2018 and 2023 is most readily seen in a comparison of the procedures, which is presented in Table 2. The comparison shows that the Court retained the two-tier medical structure and the requirement of attestation, which it regarded as necessary to protect against abuse, while removing the elements that required the participation of the judiciary and the district administration.

Table 2. Procedure for giving effect to an Advance Medical Directive

Feature	Guidelines of 2018	Guidelines as modified on 24 January 2023
Attestation of the directive	Two attesting witnesses and countersignature by a Judicial Magistrate of First Class	Two witnesses; attestation before a notary or a gazetted officer in place of the magistrate
First-tier review	Hospital medical board	Primary Medical Board: treating physician and at least two subject experts
Experience of experts	Twenty years in the relevant specialty	At least five years in the relevant specialty
Second-tier review	Board constituted by the Collector	Secondary Medical Board: a registered medical practitioner nominated by the district Chief Medical Officer and at least two other experts who were not on the Primary Board
Role of the magistrate	Visit to the patient and authorisation of the decision	Hospital conveys the boards' decision and the nominee's consent to the JMFC
Time for each board	No equivalent short time frame in the original guidelines	Opinion preferably within forty-eight hours of referral

Three observations follow. First, the change from a magistrate to a notary or gazetted officer maintained a formal check on the authenticity of the instrument at a lower expense, but also modified the nature of the check because a notary attests to a signature rather than to the maker's awareness of the consequences. Secondly, there was a decrease in the experience

requirement from twenty years to five, thus increasing the number of qualified practitioners, especially in district hospitals and smaller hospitals where specialists of higher rank are scarce. Thirdly, the continued presence of a Secondary Board with a nominee from the district Chief Medical Officer kept the "outsider" from the medical profession to a minimum in a process that otherwise was internal. All of these changes made it more usable and all of these in some way lessened the independence the original design had desired.

5. Executive and Sub-National Developments

The Mental Healthcare Act 2017 does not extend to the withdrawal of life-sustaining treatment, as Parliament has only accepted the validity of advance decision-making in a neighbouring area, namely in section 5 of the Mental Healthcare Act 2017. The executive response to terminal illness is the draft Guidelines for Withdrawal of Life Support in Terminally Ill Patients issued by the Ministry of Health and Family Welfare in September 2024, comments have been invited till 20 October 2024. The draft is clearly expressed in terms of the best interests of the child. It states that terminal illness is an irreversible or incurable condition with a certifiable prognosis of death in the near future, and lists four situations in which withdrawal of life support should be considered: brainstem death under the Transplantation of Human Organs Act 1994 (THOA); when there is medical certainty that it is improbable that the patient can benefit from the continuation of aggressive therapeutic measures, and that such continuation will cause suffering and loss of dignity; when the patient or their surrogate has signed an informed statement (prognostic awareness) and has refused to undergo such treatment; or when the procedure prescribed by the Supreme Court is followed. It establishes Primary and Secondary Medical Boards; insists that the Primary Medical Board work by consensus; and suggests a clinical ethics committee in each hospital for audit, oversight and conflict resolution.

The draft was criticized by clinicians who would not want to become liable for stress and by commentators who saw the conditions as potentially excluding someone who is not yet terminally ill from exercising their advance directive. The Government of Karnataka issued a circular on 30 January 2025 to operationalise the modified Common Cause guidelines whereby, boards comprising of three registered medical practitioners need be constituted in the hospitals and the board decision should be sent to the JMFC for forwarding to the Registrar of the High

Court. The instruments reveal that the executive branch has not replaced the judicial framework, but has started to create administrative structures around it; the language of the best interests of the child in the draft of 2024 anticipates the reasoning of the Court in 2026.

Two aspects of the draft guidelines are worthy of separate comment. The first is "withdrawal" and "withdrawal" treatment. A person who, due to their likely inability to benefit from life-saving therapy, and to experience pain and loss of dignity, may die while receiving the considered decision not to take such a course of action (including mechanical ventilation, dialysis, surgical interventions, transfusion) is a terminally ill patient. Non-initiation is clinically important because a treatment regimen that allowed for withdrawal but not withholding would lead clinicians to initiate treatment that they deemed to be unsuccessful, only to allow for later attempts to discontinue it. The second feature is the suggestion of clinical ethics committees. Such committees are an arena for the resolution of disagreement both between clinicians, and between clinicians and families, without resorting to litigation, and offer a record of reasoned decision making. However, their composition, independence and powers are issues that allow for some institutional variation within the draft.

It would also be correct to note that draft is not a binding document. Until the finalisation and notification, its conditions are proposals which inform, but do not replace, the framework set by the Supreme Court. Hospitals are thus subject to the judicial guidelines amended in 2023 and applied in 2026, to which some States add an administrative circular.

6. Analysis: The Reconfigured Architecture

6.1 A re-layering rather than a replacement

The phrase 'from autonomy to best interests' needs to be qualified. In Shanbaug, the standard applied was already best interests, as there was no directorate and the patient was unable to communicate. Common Cause raised the concept of autonomy as a constitutional principle, but their guidelines for patients without directives still involved a best interest's analysis. The autonomy was not lost by Harish Rana, but it was applied to the larger group of patients who do not have a directive. The development is thus described as a layered structure, as detailed in Table 1; the second is by far larger than the first.

Table 1. Phases in the Indian law of treatment withdrawal

Phase	Principal authorities	Locus of decisional authority	Operative standard
Judicial supervision (1996–2011)	*Gian Kaur*; *Aruna Shanbaug*	High Court acting as parens patriae on a petition by a next friend	Best interests of the patient, determined by a court-appointed medical committee
Constitutionalised autonomy (2018–2023)	*Common Cause* (2018); order of 24 January 2023	The executor of an Advance Medical Directive, verified by hospital boards	Expressed wishes of the patient; best interests where no directive exists
Institutional best interests (2024–2026)	MoHFW Draft Guidelines; *Harish Rana*	Primary and Secondary Medical Boards, with the family and, where necessary, the Court	Medical futility, irreversibility, dignity and the family's considered view

6.2 The autonomy deficit and its causes

This change is attributed to the failure of the directive, in significant part. It has been reported that no AMD had been implemented in the five years following 2018 which implies that the costs associated with the procedural design of AMD, the need for magistration, and the two-stage review (two boards and a magistrate) outweighed the benefits for those who could have benefitted from it. The 2023 change lowered these costs, but a directive is still a document which needs to be carried out by a competent adult well in advance of illness, stored in an accessible place, and available when needed by the hospital that is treating the individual. There is not sufficient knowledge of such instruments, nor is there a culture of advance care planning in India. There will therefore be only a small proportion of cases dealt with under

the system for which there is prior planning and for the foreseeable future the courts and hospitals will be left to deal with the remainder by reference to what the patient would have wanted, or what is in the patient's interests.

6.3 The indeterminacy of the best-interests standard

The best interest's standard is appealing due to its lack of a need for evidence of the patient's wishes, but has been argued that it leaves the substance of the standard to the decision-maker. In 2026, the Court recognized that there is no "straight-jacket" formula, and listed factors that should be taken into account, but not rules. Two risks follow. The first is that substituted judgment and best interests are two separate standards that can be combined and become a "mystery of which one or both are doing the work. The reconstruction of the preferences would not have arisen so clearly in the 2026 case, because the wishes of the family and the views of the boards coincided, but it will in a contested case. Secondly, any assessment of dignity and quality of life might carry with its preconceptions about disability that the patient, if he or she could, would have disapproved of. A convincing description of the standard would need a carefully planned and evidence-based investigation process, independent assessment, and the documentation of the evidence for each component, something that the current guidelines do not explicitly call for boards to do.

6.4 The concentration of authority in institutional decision-makers

In 2023, the magistrate and the Collector were eliminated from the process and certification/review was delegated to the medical profession. In the draft guidelines of 2024, that remains the case and includes hospital ethics committees. It is justifiable because of speed and skill, and the 2023 hearings prove that the judicial path was de facto closed. It nevertheless shifts a constitutional question from an autonomous public entity to entities set up by or closely linked to the entity that provides the treatment. There is one practitioner nominated by the district Chief Medical Officer to the Secondary Board, but there is no provision for the patient to be heard, or for the views of a dissenting relative to be heard, or for the decisions of the board to be reviewed at regular intervals. There is a remedy available which is provided by the High Court, but it requires the capacity of the injured party to pursue the remedy under Article 226.

6.5 Clinically assisted nutrition and hydration

The classification of CANH as medical treatment ends all the dispute on whether withdrawal was a case of starvation, which had been considered by the Delhi High Court [6]. It mirrors the House of Lords Bland approach to Indian law and is in keeping with the clinical view that tube feeding should be professionally initiated and monitored and complications professionally managed. Perhaps its impact is more moderate than most realize: the thousands of patients who suffer from long-term disorders of consciousness and remain tube-fed without ventilated were once excluded from the category of persons with whom treatment could be discontinued. The classification also underlines the significance of what the Court says in relation to palliative care: "a dying process of some length may occur on withdrawal of all food and drink, and requires skilled care of symptoms.

6.6 Palliative care as a structural precondition

A best interests regime is only legitimate if there are alternatives to withdrawal. Where families are unable to access palliative care, the choice of whether to continue with intensive treatment or to withdraw is not a choice for the family. Evidence on access is unfavourable. Between seven and 10 million people in India are estimated to need palliative care, with only 4 per cent having access, and with 98.3 per cent of those patients in the final stage of cancer having an unmet need. The density of centres in operation was 526 per 10 million people in 2022 with the highest density in Lakshadweep, Goa and Kerala (close to 100%), the lowest in Madhya Pradesh, Odisha and Bihar (<10), and lower in rural areas than in urban areas across all comparisons. The data suggest that most of the Indian patients will experience a best-interests inquiry without specialist support and this raises the possibility that withdrawal may be advocated due to resource scarcity as well as futility. The Court's requirement to include a palliative care plan in the withdrawal process is therefore a requirement of any valid regime and a benchmark which, given the currently available evidence, it is unlikely that many parts of the country will be able to currently meet.

6.7 Judge-made law and the case for legislation

It is based on the power of the Court under Article 142 and has been amended by order, by clarification and by application for over 8 years. The risks are that the status of the 2024 draft remains uncertain, that the way each State implements the draft differs significantly, and that practitioners do not have statutory safeguards for their actions when taken in good faith. The problem is that the procedure for 2018, which had to be rectified in 2023, demonstrates the shortcomings of judicial design of a procedure without legislative consultation and empirical testing. A statute might define what is meant by a terminal illness and permanent unconsciousness, set up the composition and responsibilities of boards, establish a register of directives, give immunity to practitioners who follow the guidelines and provide funding for palliative care, which a court cannot do by guideline.

6.8 Equity and the risk of unequal application

The practicality of a framework that emphasizes institutional determination brings up an issue of equal protection. The conditions that make the process workable, a hospital capable of constituting two boards, specialists with the requisite experience, documentation of prognosis and a family able to engage with the process, are unevenly distributed. The information on palliative care reveals significant inter-State and rural-urban variations, and it is hard to believe that the ability to conduct a compliant board process is more evenly distributed. Two risks follow. In well-resourced urban hospitals a legitimate and dignified process of limitation of treatment may be available to the patient; in other hospitals, the patient is denied or subjected to an informal process of limitation of treatment not legally mandated. On the other hand, in a situation where the cost of continuing intensive care is a burden on the family, that may affect a decision that is formally expressed as one of best interests. The regime thus needs to be monitored based on the demographic and institutional characteristics of cases where treatment is discontinued, but there is no systematic public information of this type.

6.9 Implications for clinicians and hospitals

The impact of the decisions for the treating team is to provide a legitimate option with previously uncertain legal implications of restricting the treatment of persons. The Court in Common Cause and in the order of 2023 outlined the process for withdrawal to become lawful,

and it is the practitioner's primary line of defense when the process is followed. However, the guidelines do not specify in detail the level of immunity that will be provided for practitioners acting in good faith and following the process and this is where much of the concern from clinicians has been raised about the draft guidelines. A parallel responsibility is preparing the hospital: they need to form boards, keep records of the proceedings, train staff to recognise the cases and communicate with the families. The decision of 2026 also imposes a positive obligation upon the treating institution to provide palliative and end-of-life care in addition to withdrawal, which will lead to investment in services and investment in clinical education which most institutions are not currently investing in.

6.10 Constitutional legitimacy of judge-made regulation

The framework is one of the powers of the Supreme Court in Article 142 of the Constitution to make "such orders as are necessary for doing complete justice" in an area where there has been no legislative action. Use of that power to establish a complete regulatory structure—with hospitals, boards and magistrates doing their tasks—leads to the complaint that the Court is taking on a legislative role. What the Court has said in reply is that the guidelines are provisional, and work until Parliament takes the place of the Court. The problem is that provisional arrangements become "real" when they are not legislated away, and when the Court gets caught up in the process of reworking its own scheme as in 2023, and also in the process of applying it on a case-by-case basis as in 2026. The role is also institutionally expensive for the Court, as it is not equipped to have consultation, collect data, pilot test, etc., as a legislature or expert committee. It also has a high cost to the framework, because a scheme which can be changed by order from time to time is not as stable as those who have to apply it to it want. The constitutional objection is offset, however, by the fact that the Court was taking action to safeguard a right under Article 21 and that the other was the denial of any lawful means. Law-making is thus based on institutional competence and legitimacy rather than on a lack of power.

6.11 Synthesis: the decisional hierarchy implied by the case law

Put together, the decisions provide an implicit hierarchy of decisional standards. The framework aims to respect the patient's legitimate refusal, either contemporary or documented in an AMD, when the procedural requirements are complied with. In the absence of any

directive, the framework was based on the convergence of the views of the next of kin and the medical boards on the best interests of the patient, and the Court in 2026 found the convergence of views on the best interests of the patient decisive. In the absence of consensus within the family or among the boards, the case is remanded to the High Court or Supreme Court as the final adjudicator of best interests, in the Shanbaug tradition. This hierarchy can be explained logically, from most to least evidence of the patient's own preference to the most neutral decision maker. It is, however, nowhere to be found in one authoritative text, and must be pieced together from rulings rendered in various contexts.

The hierarchy also expresses the main contradiction of this current government. For the majority of cases, best interests is the most difficult to prove and most reliant on integrity and competence of the decision makers. The greatest constitutional support is for the standard with the fewest. A developed framework would aim at closing such a gap by either improving the percentage of patients with recorded preferences, by improving the process of advance care planning and making a working register, or by enhancing the procedural aspect of the best-interests determination until it closely resembles the evidentiary process of autonomy-based determination, as closely as possible. The recommendations in Section 7 are for both purposes.

7. Recommendations

The following four reforms arise from the analysis. The first is that Parliament should pass a legislation that sanctifies the Common Cause concept as amended and the best interests principle as defined in Harish Rana with a clear regulation of the interplay between the two. Second, the best interests decision should be statutory or be decided upon by enforceable guidelines which call for a record of medical prognosis, an independent assessment of the patient's previously expressed values (if known), and a recording of the reasons of each board (with rights of review for an opposing relative). Thirdly, a national or state-based register of AMDs should be created with linkage to digital health records, to enable the availability of directives when needed. Fourth, and last, in law and in the allocation of public resources, the withdrawal of treatment should be tied to the provision of palliative care, and new palliative care services should be targeted at States and rural districts without them.

There are three additional measures of implementation. Fifthly, the statute or final rules should explicitly address protecting practitioners and hospitals that participate in the process in good faith and in accordance with the statute's requirements, as this is why some clinicians have expressed reluctance about the structure [5]. Sixthly, hospitals that form the boards should be mandated to keep standardised records of each determination, such as the prognosis, evidence of patient wishes, family views and reasons for the decision, and provide anonymised data to a state or national authority so that the framework could be evaluated empirically, which it is not now. Seventhly: Medical and nursing courses should provide lessons in the art of prognostication and communication with the families, and lessons in the identification of cases in which treatment should be limited; for the proper working of the boards depends upon the skill of the practitioners who staff them.

These measures are also to be applied in a certain sequence. The introduction of the administrative system of the Ministry of Health and Family Welfare and State governments for record keeping, training and clarification of professional protection can be short-term measures while legislation and registration can be medium-term. The Court's 2026 ruling that withdrawal be accompanied by a palliative care plan provides a reason for starting with palliative care services being expanded first as this is a prerequisite to the legitimacy of all other reforms.

8. Limitations and Directions for Further Research

There are a number of limitations to the study. It is doctrinal, and it does not rely on interviews with clinicians or hospital ethics committee members or with patients and families; instead its observations of the workings of the framework are based on the reported record of the cases and on published data. The empirical evidence for palliative care it relies on is restricted to one recent study and there is no systematic national data available on the number of palliative care directives performed, the number of board decisions made and the outcomes of applications according to the 2023 guide. The analysis of the 2026 decision is based on the content of the reported case, and requires checking against the reported text; and the paper has not addressed how subsequent decisions of High Courts might interpret the 2026 decision.

The next steps in the research suggest several avenues for future research. The functioning of Primary and Secondary Medical Boards, such as the time taken, the percentage of successful

applications and the reasons for the rejection of applications, would be assessed in an empirical way, which would test the assumptions underlying the 2023 modification. In-depth qualitative research with families and clinicians could shed light on how the best interests principle is perceived and utilized. A comparative study of the statutory provisions of the jurisdictions which have codified the doctrine of withdrawal of treatment would help in formulating an Indian statute. Finally, the issue raised in Section 6.3 of "disability assumptions" in dignity and quality of life assessments will be tackled in doctrinal work on the link between the best interest's standard and the rights of PWDs.

9. Conclusion

Judicial structures to make decisions about the end-of-life in India have been built over three decades. A re-layering of principles rather than a displacement occurs as judicial permission in Shanbaug is replaced by the constitutionalisation of autonomy in Common Cause, and in a far greater number of patients where there is no directive, best interests prevail. The change reflects the reality of a system of autonomy that has largely failed to work in practice, and it has moved the decision-making power of physicians and families away from individuals and courts, and onto medical boards. Its legitimacy relies on the inadequately developed protection measures, including the absence of a determinate best interest's enquiry, the lack of independent oversight of institutional decisions and a non-functional palliative care system. If these issues are not legislated, then the law will still rely on the discretion of the entities it has entrusted and on the power of the Supreme Court to oversee them on a case-by-case basis.

References

1. *Gian Kaur v State of Punjab* (1996) 2 SCC 648 (Supreme Court of India, Constitution Bench).
2. *Aruna Ramchandra Shanbaug v Union of India* (2011) 4 SCC 454 (Supreme Court of India, judgment of 7 March 2011).
3. *Common Cause v Union of India* (2018) 5 SCC 1 (Supreme Court of India, Constitution Bench, judgment of 9 March 2018).

4. *Common Cause (A Registered Society) v Union of India* 2023 SCC OnLine SC 99 (Supreme Court of India, Constitution Bench, order of 24 January 2023, modifying the guidelines in).
5. Ministry of Health and Family Welfare, Government of India, *Guidelines for Withdrawal of Life Support in Terminally Ill Patients* (Draft), September 2024.
6. *Harish Rana v Union of India* 2026 INSC 222 (Supreme Court of India, Miscellaneous Application, judgment of 11 March 2026).
7. "Access to palliative care in India: situational analysis and modeling of access from public healthcare centers", *ecancermedicalscience* (published 19 November 2025), PMC12904676.