RECONCEPTUALISING THE 'BEST INTEREST' STANDARD IN END-OF-LIFE DECISION-MAKING: A CRITICAL CONSTITUTIONAL ANALYSIS OF THE HARISH RANA CASE

[1]DR. KHUSHBOO PRAJAPAT

Abstract: This article examines the evolving jurisprudence of end-of-life decision-making in India, particularly following the recognition of the right to die with dignity under Article 21 in Common Cause v. Union of India. It critically analyses the "best interest" standard as applied in the Harish Rana case, arguing that despite its protective intent, the doctrine remains conceptually vague and inconsistently implemented.

The study highlights how the current framework privileges institutional decision-making, primarily through medical boards, over individual autonomy, thereby reinforcing elements of paternalism. The limited practical use of advance directives further weakens the patient's voice, creating a gap between constitutional ideals of dignity and their real-world application.

Through a comparative lens, the article identifies the absence of a structured method for incorporating patient preferences into legal determinations. It contends that the existing approach inadequately balances autonomy and welfare, undermining the coherence of this constitutional doctrine.

The article advocates for a reconceptualised "best interest" standard centred on autonomy, supported by robust advance directive mechanisms, clearer substituted judgment principles, and a redefined role for medical expertise. Such reform is essential to align legal practice with the transformative constitutional vision of dignity and personal liberty.

Keywords: End-of-life decision-making; Best interest standard; Advance directives; Constitutional dignity.

[1] **Assistant Professor, M.D. Law College, Rajapark, Jaipur**

1. INTRODUCTION

The question of end-of-life decision-making presents a profound intersection of law, ethics, and medicine, compelling courts to navigate the delicate balance between the sanctity of life and the autonomy of the individual. In India, this discourse has undergone a gradual yet significant transformation, particularly with the constitutional expansion of Article 21 to include not merely the right to live, but the right to live with dignity. However, when life approaches its terminal stage, the determination of what constitutes "dignity" becomes deeply contested, especially in cases where the patient is no longer capable of articulating informed consent.

Within this contested terrain, the "best interest" standard has emerged as a central doctrinal tool guiding judicial and medical decision-making. Conceptually, the standard seeks to prioritize the welfare of the patient, particularly in situations involving incapacity. Yet, its application in the Indian legal framework remains fraught with ambiguity. The absence of a clearly defined normative structure raises fundamental concerns: whether the standard genuinely reflects the patient's own wishes and values, or whether it enables courts and medical authorities to impose their own perception of welfare under the guise of beneficence.

The decision in Harish Rana case [2] assumes particular significance in this context. Emerging in the aftermath of the landmark ruling in Common Cause v. Union of India[3], which constitutionally recognized passive euthanasia and the validity of advance directives, the Harish Rana case represents a critical moment in the operationalisation of end-of-life jurisprudence. While the earlier decision laid down the normative foundation by affirming the right to die with dignity, the Harish Rana judgment tests the practical application of these principles through the lens of the "best interest" standard[4].

A close examination of the case reveals that the judiciary continues to grapple with competing considerations, individual autonomy, medical expertise, familial involvement, and the State's protective role as parens patriae. Although the judgment ostensibly adheres to the constitutional mandate of preserving dignity, its reasoning reflects a cautious, and at times inconsistent, reliance on institutional decision-making mechanisms such as medical boards. This

[2] Harish Rana v. Union of India &Ors. (2026) INSC 222.
[3] (2018) 5 SCC 1
[4] Harish Rana v. Union of India &Ors. (2026) INSC 222.

raises a critical doctrinal question: whether the "best interest" standard, as currently applied, operates as a safeguard for patient welfare or as a mechanism of controlled paternalism that marginalizes individual autonomy.

The ambiguity inherent in the standard becomes more evident when viewed against its comparative origins. In jurisdictions such as the United Kingdom, the "best interest" test has evolved to incorporate a structured assessment of the patient's prior wishes, beliefs, and values, thereby aligning the doctrine more closely with autonomy-based reasoning. Indian courts, while occasionally drawing upon such jurisprudence, have not consistently integrated these elements into their decision-making framework. As a result, the application of the standard remains uneven, often privileging medical opinion over the subjective dimensions of patient identity and choice.

The Harish Rana case[5] thus provides an important site for critical engagement. It highlights the gap between constitutional aspiration and judicial implementation, particularly in the context of end-of-life care. By foregrounding the tensions between autonomy and paternalism, the case underscores the need for a more coherent and principled articulation of the "best interest" standard, one that is firmly anchored in constitutional morality rather than institutional convenience.

This article argues that the existing framework governing end-of-life decision-making in India requires a fundamental reconceptualisation. It contends that the "best interest" standard, in its current form, lacks the doctrinal clarity necessary to function as a reliable constitutional tool. Through a critical analysis of the Harish Rana judgment, supported by relevant jurisprudence and limited comparative insights, the article seeks to develop a more robust, autonomy-centric understanding of the doctrine. Such a reconceptualisation is essential not only to ensure consistency in judicial outcomes but also to uphold the transformative promise of the Constitution in safeguarding dignity at the end of life.

2. Conceptual Foundations of the "Best Interest" Standard

I. Between Welfare and Autonomy: Theoretical Contours of the Standard

The "best interest" standard, though frequently invoked in judicial discourse as a neutral and benevolent principle, is in reality a deeply layered construct shaped by competing

[5] Harish Rana v. Union of India &Ors. (2026) INSC 222.

ethical and legal philosophies. At its conceptual core lies the principle of beneficence, the obligation to act in a manner that promotes the welfare of the patient. In situations where an individual is incapable of expressing informed consent, the law steps in to substitute this absence of agency with an external determination of what would best serve the individual's well-being. However, this seemingly straightforward substitution conceals a fundamental tension: whether such determinations genuinely reflect the patient's own values or merely impose an institutional understanding of welfare.

This tension becomes particularly pronounced when the "best interest" standard is situated within the broader framework of personal autonomy. Autonomy, as a foundational principle of modern constitutional and medical jurisprudence, emphasizes the individual's right to make decisions concerning their own body and life, even when such decisions may appear irrational or undesirable to others. In the context of end-of-life decision-making, autonomy manifests in the recognition that the right to life under Article 21 includes the right to refuse treatment and, by extension, the right to die with dignity. Yet, when the patient is incapacitated, autonomy becomes difficult to operationalise, leading courts to rely on surrogate standards such as "best interest."

It is within this space that the standard begins to oscillate between two competing orientations. On one hand, it aspires to preserve autonomy through mechanisms such as substituted judgment, wherein decision-makers attempt to reconstruct what the patient would have chosen if competent. On the other, it often defaults to a more paternalistic model, where medical professionals and courts determine what ought to be done in the perceived welfare of the patient. The shift from one orientation to the other is rarely explicit; rather, it is embedded within the reasoning processes of courts, often justified through the language of care, protection, and dignity.

The indeterminacy of the standard thus becomes its defining characteristic. Unlike clearly structured legal tests, the "best interest" principle does not provide a fixed hierarchy of considerations. It allows, and at times encourages, a blending of medical, ethical, and social factors without clarifying how conflicts between them are to be resolved. Consequently, the standard risks functioning less as a principled doctrine and more as a flexible justification, capable of accommodating divergent outcomes under the same conceptual label.

II. Doctrinal Evolution: From Protective Paternalism to Conditional Autonomy

The trajectory of the "best interest" standard in Indian jurisprudence reflects a gradual yet incomplete shift from a protection-oriented approach to one that tentatively acknowledges autonomy. Early judicial attitudes toward end-of-life decisions were firmly anchored in the sanctity of life doctrine, which left little room for considerations of individual choice. This position began to evolve with the Supreme Court's engagement with passive euthanasia in Aruna Ramachandra Shanbaug v. Union of India[6], where the Court permitted the withdrawal of life-sustaining treatment under strict conditions.

In Aruna Shanbaug's case[7], The Court introduced a procedural framework involving judicial oversight and the constitution of medical boards to determine whether withdrawal of treatment would be in the patient's best interest. While this marked a significant doctrinal shift, it also entrenched a model of decision-making heavily reliant on institutional authority. The patient's voice, in the absence of explicit prior expression, remained largely mediated through medical and judicial actors. The "best interest" standard, as applied in this context, thus reflected a cautious form of paternalism, one that sought to protect the patient but did not fully embrace the autonomy-based dimensions of the right to life.

A more decisive articulation of autonomy emerged in Common Cause v. Union of India[8], where the Supreme Court recognized the validity of advance directives and affirmed that the right to die with dignity is an integral component of Article 21. This decision signaled a normative shift toward respecting individual choice, even in matters concerning the termination of life-sustaining treatment. By acknowledging that individuals have the right to determine the course of their own medical care in advance, the Court appeared to recalibrate the balance between autonomy and welfare.

However, the transition from principle to practice has remained uneven. Despite the recognition of advance directives, their implementation has been hindered by procedural complexities and limited public awareness. Consequently, in many cases, courts continue to rely on medical assessments and institutional safeguards, thereby reintroducing elements of paternalism into the

[6] (2011) 4 SCC 454
[7] Ibid
[8] (2018) 5 SCC 1

decision-making process. The "best interest" standard, instead of evolving into a clear autonomy-centric test, continues to operate as a hybrid construct, partly informed by individual rights and partly constrained by institutional caution.

Comparative developments offer a useful, albeit limited, lens to understand this tension. In Airedale NHS Trust v. Bland[9], the House of Lords recognized that the continuation of life-sustaining treatment may not always serve the patient's best interest, particularly where it lacks therapeutic purpose. Subsequent legal developments in the United Kingdom refined this position by requiring decision-makers to consider the patient's prior wishes, beliefs, and values. While Indian courts have occasionally drawn upon such reasoning, the absence of a similarly structured statutory framework has resulted in a more discretionary and less predictable application of the standard.

III. Persistent Ambiguities and the Need for Conceptual Clarity

The coexistence of welfare-oriented reasoning and autonomy-based principles within the "best interest" framework has led to a state of doctrinal uncertainty. Courts are often required to navigate complex factual scenarios without the guidance of a clearly defined legal test, resulting in decisions that may vary significantly in their reasoning and outcomes. This lack of consistency not only undermines the predictability of the law but also raises concerns about the protection of fundamental rights.

One of the most significant challenges lies in the continued dominance of medical opinion in determining what constitutes the patient's best interest. While medical expertise is undeniably crucial, its elevation to a determinative status risks overshadowing the subjective dimensions of the patient's identity, values, beliefs, and personal preferences that are central to the concept of dignity. The reliance on medical boards, though intended as a safeguard, may inadvertently transform the "best interest" standard into a clinically driven assessment rather than a constitutionally grounded inquiry.

[9] [1993] AC 789 (HL).

Equally problematic is the limited operationalisation of advance directives. Although recognized as legally valid, their practical impact remains constrained, thereby weakening the autonomy-based dimension of end-of-life decision-making. In the absence of clear and accessible mechanisms for recording and enforcing such directives, the system continues to default to substituted decision-making, often guided by institutional considerations rather than individual intent.

The cumulative effect of these ambiguities is that the "best interest" standard functions as an open-ended concept, capable of accommodating both autonomy and paternalism without fully committing to either. This conceptual fluidity, while offering flexibility, also creates the risk of arbitrariness. It is within this uncertain doctrinal landscape that the Harish Rana case[10] assumes critical importance, as it reveals how these unresolved tensions manifest in judicial reasoning.

A meaningful reconceptualisation of the standard, therefore, requires more than incremental adjustments. It demands a reorientation of the doctrine toward a framework where autonomy is not merely one of several factors, but the guiding principle, supported, rather than supplanted, by considerations of welfare and medical expertise. Only through such a recalibration can the "best interest" standard align with the constitutional commitment to dignity and transform from a flexible abstraction into a principled legal tool.

3. Case Analysis: The Harish Rana Judgment

I. Facts, Judicial Approach, and the Framing of the Issue

The decision in Harish Rana case emerges at a critical juncture in India's evolving end-of-life jurisprudence, where the constitutional recognition of dignity confronts the practical realities of medical decision-making. The case, as reflected in the record, involved a patient in a severely compromised medical condition, incapable of expressing informed consent, thereby necessitating surrogate decision-making regarding the continuation or withdrawal of life-sustaining treatment. The central issue before the court was not merely medical in nature, but fundamentally constitutional: how to determine the course of action that would

[10] Harish Rana v. Union of India &Ors. (2026) INSC 222.

align with the patient's "best interest" while remaining faithful to the guarantees under Article 21.

At the outset, the court framed the issue within the established legal position laid down in Common Cause v. Union of India[11], acknowledging that the right to life includes the right to die with dignity. However, the absence of an advance directive or clearly articulated prior wishes of the patient shifted the focus of adjudication from autonomy to substituted decision-making. In doing so, the court effectively positioned itself as the ultimate arbiter of the patient's welfare, mediated through medical expertise and institutional safeguards.

The factual matrix of the case reveals a heavy reliance on clinical assessments, particularly the opinion of medical boards constituted to evaluate the patient's condition and prognosis. While such reliance is consistent with the procedural framework developed in earlier cases, it also underscores the extent to which the determination of "best interest" is shaped by medical discourse. The patient, as a subject of rights, appears largely absent from the narrative, replaced instead by an object of clinical evaluation.

II. Judicial Reasoning and the Dominance of Institutional Paternalism

A close reading of the judgment indicates that the court's reasoning is anchored in a cautious and protection-oriented approach. The emphasis on medical opinion, coupled with the invocation of the State's parens patriae jurisdiction, reflects a judicial preference for minimizing risk rather than maximizing autonomy. While the court ostensibly seeks to act in the patient's best interest, the criteria for such determination remain largely implicit, derived from a combination of medical prognosis, perceived quality of life, and institutional prudence.

This approach reveals a subtle yet significant shift from the autonomy-centric framework envisaged in Common Cause. Instead of prioritizing what the patient might have wanted, the court appears to focus on what ought to be done in the circumstances, as assessed by medical professionals. The "best interest" standard, in this sense, functions less as a mechanism for

[11] (2018) 5 SCC 1

preserving autonomy and more as a justificatory framework for decisions taken by external authorities.

The role of the medical board is particularly instructive in this regard. While intended as an expert body to assist judicial determination, its opinion often assumes a determinative character. The court's deference to medical expertise, though understandable given the technical nature of the issues involved, raises concerns about the marginalization of non-medical considerations. Questions relating to dignity, personal values, and the subjective experience of suffering are subsumed within clinical assessments, thereby narrowing the scope of the inquiry.

Furthermore, the judgment reflects an implicit hierarchy in which the preservation of life is treated as the default position, and any deviation from it requires strong justification. This presumption, though rooted in the traditional sanctity of life doctrine, sits uneasily with the constitutional recognition of the right to die with dignity. The result is a doctrinal tension: while the court acknowledges autonomy in principle, its application remains constrained by a deep-seated reluctance to relinquish control over life-ending decisions.

III. Constitutional Tensions: Autonomy, Dignity, and the Limits of "Best Interest"

The Harish Rana judgment brings into sharp focus the unresolved tension between autonomy and paternalism within Indian end-of-life jurisprudence. Although Article 21 has been expansively interpreted to include the right to live with dignity, and by extension the right to die with dignity, the operational framework for giving effect to this right remains underdeveloped. The "best interest" standard, as applied in the case, illustrates this gap between constitutional aspiration and judicial practice.

One of the most significant limitations of the judgment lies in its failure to adequately engage with the concept of substituted judgment. In the absence of an advance directive, the court could have attempted to reconstruct the patient's likely preferences based on available evidence, family testimony, lifestyle, beliefs, or prior expressions. Instead, the analysis remains largely confined to objective factors, thereby privileging a welfare-based approach over an autonomy-oriented one. This not only dilutes the centrality of individual choice but also risks transforming the "best interest" standard into a tool of institutional convenience.

The comparative dimension further highlights this limitation. In jurisdictions such as that considered in Airedale NHS Trust v. Bland[12], the determination of best interest has evolved to include a holistic assessment of the patient's identity, incorporating both medical and non-medical factors. The Indian approach, as reflected in Harish Rana, remains more constrained, lacking a structured methodology for integrating these elements. The selective borrowing of comparative principles, without their underlying safeguards, contributes to doctrinal inconsistency.

Another critical concern is the limited role accorded to advance directives within the judgment. Despite their recognition in Common Cause case[13], their absence in the present case leads to a reversion to institutional decision-making. This highlights a broader systemic issue: the lack of effective mechanisms for creating, recording, and enforcing advance directives, which in turn weakens the autonomy-based framework envisioned by the Supreme Court.

Ultimately, the Harish Rana case reveals that the "best interest" standard, in its current form, is insufficiently equipped to function as a robust constitutional tool. Its indeterminacy allows for flexibility, but at the cost of clarity and consistency. More importantly, its application tends to favor paternalistic reasoning, thereby undermining the transformative potential of Article 21[14].

The analysis of the Harish Rana case demonstrates that the central challenge is not merely the absence of legal principles, but the lack of a coherent framework for their application. The "best interest" standard, as presently understood, oscillates between competing values without providing a clear normative anchor. This necessitates a fundamental reconceptualisation of the doctrine, one that places autonomy at its core while retaining necessary safeguards.

4. Critique: Paternalism, Autonomy, and the Illusion of the "Best Interest" Standard

I. The Persistence of Paternalism in a Rights-Oriented Framework

[12] [1993] AC 789 (HL).
[13] Common Cause v. Union of India (2018) 5 SCC 1
[14] Harish Rana v. Union of India &Ors. (2026) INSC 222.

The evolution of end-of-life jurisprudence in India, particularly after Common Cause v. Union of India[15], ostensibly signals a decisive shift toward an autonomy-driven understanding of the right to life under Article 21. By recognizing the right to die with dignity and validating advance directives, the Supreme Court appeared to affirm that individual choice must occupy a central position in decisions concerning the termination of life-sustaining treatment. However, a closer examination of subsequent judicial practice, as exemplified by the Harish Rana case, reveals that this transition remains incomplete and, in many respects, illusory.

The continued reliance on the "best interest" standard operates as a subtle mechanism through which paternalistic decision-making is preserved within a formally rights-oriented framework. While the language of the standard suggests a patient-centric approach, its application frequently shifts the locus of decision-making away from the individual and toward institutional actors, courts, medical boards, and, to a lesser extent, family members. The result is a model in which autonomy is acknowledged in principle but constrained in practice.

This persistence of paternalism is not accidental; rather, it reflects a deeper structural anxiety within the legal system about relinquishing control over life-and-death decisions. The judiciary, functioning as the ultimate guardian of constitutional values, often adopts a cautious approach that prioritizes the preservation of life and the avoidance of error. In doing so, it reintroduces a protective logic that sits uneasily with the autonomy-based reasoning articulated in Common Cause. The "best interest" standard thus becomes a doctrinal bridge that allows courts to navigate this tension without fully committing to either paradigm.

II. The Conceptual Indeterminacy of "Best Interest"

One of the most significant challenges associated with the "best interest" standard lies in its conceptual indeterminacy. Unlike structured legal tests that provide clear criteria and a defined hierarchy of considerations, the standard operates as an open-ended concept, capable of accommodating a wide range of factors without specifying how they are to be weighed. This

[15] (2018) 5 SCC 1

flexibility, while seemingly advantageous, undermines the predictability and coherence of judicial decision-making.

In the context of the Harish Rana case, this indeterminacy is particularly evident. The court's reasoning, though grounded in medical evidence and procedural safeguards, does not articulate a clear normative framework for determining what constitutes the patient's best interest. Instead, the conclusion appears to emerge from a composite assessment of medical prognosis, perceived quality of life, and institutional caution. The absence of a clearly defined standard raises concerns about the extent to which such decisions are guided by principle rather than discretion.

This lack of clarity has broader implications for constitutional jurisprudence. Article 21, as interpreted by the Supreme Court, embodies a commitment to dignity, autonomy, and personal liberty. However, when the application of these principles is mediated through an indeterminate standard, their normative force is diluted. The "best interest" test, instead of functioning as a tool for enforcing constitutional rights, risks becoming a vehicle for discretionary judgment, shaped by the subjective perceptions of decision-makers.

Moreover, the indeterminacy of the standard allows for the conflation of distinct ethical considerations. Questions of medical feasibility, quality of life, and personal dignity are often treated as interchangeable, without acknowledging their conceptual differences. This conflation obscures the central issue: whether the decision reflects the patient's own understanding of a dignified life, or merely an external assessment of what is considered acceptable.

III. The Marginalisation of Autonomy and the Limits of Substituted Judgment

A critical weakness in the current application of the "best interest" standard is its inadequate engagement with the principle of substituted judgment. In theory, substituted judgment offers a means of preserving autonomy in situations where the patient is incapable of expressing informed consent. By reconstructing the patient's likely preferences based on prior statements, beliefs, and values, it seeks to ensure that decisions are aligned with the individual's own conception of life and dignity.

However, in practice, as reflected in the Harish Rana judgment, this approach is often underutilized. The absence of an advance directive tends to shift the focus toward objective

assessments of welfare, thereby sidelining the subjective dimensions of the patient's identity. Even where family members may provide insight into the patient's preferences, their role is typically advisory rather than determinative, and their perspectives may be subordinated to medical opinion.

This marginalisation of autonomy is particularly problematic in light of the constitutional emphasis on individual agency. The recognition of advance directives in Common Cause was intended to strengthen the autonomy-based framework of end-of-life decision-making. Yet, the limited practical impact of this recognition suggests that the system continues to default to paternalistic models in the absence of formal documentation.

The reliance on substituted decision-making without a robust methodology further exacerbates this issue. Without clear guidelines on how to evaluate evidence of the patient's wishes, courts are left to navigate these questions on a case-by-case basis, often resulting in inconsistent outcomes. The "best interest" standard, in this context, becomes a fallback mechanism that prioritizes certainty and control over the more complex task of reconstructing individual intent.

IV. Medical Authority and the Clinicalisation of Constitutional Rights

Another dimension of the critique concerns the dominant role of medical authority in shaping end-of-life decisions. While medical expertise is indispensable in assessing the patient's condition and prognosis, its elevation to a determinative status raises important constitutional concerns. The "best interest" standard, as applied in practice, often transforms a fundamentally normative question, what ought to be done, into a predominantly clinical inquiry.

In the Harish Rana case[16], the opinion of the medical board plays a central role in guiding the court's decision. Although the court retains ultimate authority, its deference to medical expertise effectively narrows the scope of judicial inquiry. Issues relating to dignity, autonomy, and personal values are subsumed within clinical assessments, thereby reducing the constitutional dimension of the case to a matter of medical judgment.

[16] Harish Rana v. Union of India &Ors. (2026) INSC 222.

This process of "clinicalisation" has significant implications. It shifts the focus from the rights-bearing individual to the medicalized body, evaluated in terms of functionality and prognosis. The patient's identity as a person, with beliefs, relationships, and a subjective understanding of dignity, is overshadowed by their status as a clinical subject. The result is a form of decision-making that, while technically informed, may lack normative depth.

Furthermore, the dominance of medical authority raises concerns about accountability. Unlike courts, which are bound by constitutional principles and subject to public scrutiny, medical boards operate within a professional framework that prioritizes clinical judgment. The integration of such bodies into the decision-making process, without adequate normative guidance, risks creating a system where constitutional rights are indirectly determined by non-legal actors.

V. Comparative Insight and the Problem of Partial Transplantation

The limitations of the Indian approach become more apparent when viewed in light of comparative jurisprudence. In Airedale NHS Trust v. Bland[17], the House of Lords recognized that the continuation of life-sustaining treatment may not always serve the patient's best interest, particularly where it lacks therapeutic purpose. Importantly, subsequent legal developments in the United Kingdom have refined this principle by incorporating a structured assessment of the patient's prior wishes, beliefs, and values.

The Indian judiciary has, on occasion, drawn upon such comparative principles. However, the transplantation has been partial and selective. While the language of "best interest" has been adopted, the procedural and substantive safeguards that accompany it in other jurisdictions have not been fully integrated. This selective borrowing results in a doctrinal imbalance: the flexibility of the standard is retained, but without the constraints necessary to prevent arbitrary application.

The Harish Rana case exemplifies this problem. The reliance on medical boards and judicial discretion mirrors aspects of comparative jurisprudence, yet the absence of a structured framework for evaluating patient preferences limits the autonomy-based dimension of the

[17] [1993] AC 789 (HL).

standard. The result is a hybrid model that combines elements of welfare and autonomy without achieving coherence.

VI. Rethinking the "Best Interest" Standard: From Illusion to Principle

The critique developed above points to a fundamental conclusion: the "best interest" standard, in its current form, operates more as an illusion of objectivity than as a principled legal doctrine. Its flexibility allows courts to navigate complex cases, but at the cost of clarity, consistency, and, ultimately, the protection of individual rights.

A meaningful reconceptualisation of the standard requires a shift in orientation. Autonomy must be positioned as the primary guiding principle, with welfare considerations functioning as supportive factors rather than overriding ones. This would entail a greater emphasis on substituted judgment, supported by clearer guidelines on how to evaluate evidence of the patient's wishes. It would also require a rethinking of the role of medical authority, ensuring that clinical assessments inform but do not determine the outcome.

Equally important is the need to strengthen the institutional framework for advance directives. By making it easier for individuals to record and enforce their preferences, the legal system can reduce its reliance on surrogate decision-making and enhance the autonomy-based dimension of end-of-life jurisprudence.

The Harish Rana case, when viewed through this lens, serves not merely as an instance of judicial decision-making, but as a reflection of the broader challenges facing Indian constitutional law in this domain. It underscores the need for a more coherent and principled approach, one that moves beyond the indeterminacy of the "best interest" standard and aligns more closely with the transformative vision of the Constitution.

5. Reconceptualising the "Best Interest" Standard: A Constitutional Way Forward

I. From Doctrinal Ambiguity to Normative Clarity

The analysis of the Harish Rana case reveals a fundamental paradox at the heart of Indian end-of-life jurisprudence: while constitutional doctrine has evolved to recognise autonomy and dignity as

central to Article 21, the operational standard governing decision-making, the "best interest" test, continues to function within an indeterminate and, at times, paternalistic framework. This disjunction between constitutional aspiration and judicial application necessitates not merely incremental reform, but a principled reconceptualisation of the doctrine itself.

At present, the "best interest" standard suffers from a lack of normative clarity. Its flexibility allows courts to accommodate diverse considerations, but this very openness results in inconsistency and unpredictability. A constitutional doctrine, particularly one that directly implicates the right to life and dignity, cannot remain conceptually fluid. It must be anchored in a clearly articulated set of principles that guide decision-making while limiting the scope for arbitrariness.

The first step in this reconceptualisation is to redefine the hierarchy of values underlying the standard. Rather than treating autonomy, welfare, and medical opinion as co-equal considerations, the doctrine must explicitly recognize autonomy as the primary normative anchor, with other factors playing a supplementary role. Such a shift would align the standard more closely with the constitutional vision articulated in Common Cause v. Union of India, where dignity and self-determination were placed at the forefront of Article 21.

II. Recentring Autonomy: Strengthening Substituted Judgment and Advance Directives

A meaningful autonomy-centric framework requires a robust mechanism for capturing and implementing the patient's preferences. In this regard, the recognition of advance directives in Common Cause represents a significant doctrinal advancement. However, as the Harish Rana case illustrates, the absence or underutilisation of such directives often leads to a reversion to institutional decision-making.

To address this gap, it is imperative to strengthen both the legal framework and practical accessibility of advance directives. This may include:

- Simplifying procedural requirements for their execution
- Establishing centralized or digital registries
- Enhancing public awareness through policy initiatives

By ensuring that individuals can meaningfully record their preferences in advance, the legal system can reduce its reliance on surrogate decision-making and more faithfully reflect the autonomy of the patient.

In situations where advance directives are absent, the doctrine must place greater emphasis on substituted judgment. Courts should be required to engage in a structured inquiry into the patient's likely preferences, drawing upon evidence such as:

- Prior statements or conduct
- Religious or moral beliefs
- Testimony of family members and close associates

This approach would shift the focus from an abstract assessment of welfare to a more personalized understanding of dignity, thereby preserving the individual's agency even in conditions of incapacity.

III. Recalibrating the Role of Medical Authority

While medical expertise is indispensable in end-of-life cases, its role must be carefully calibrated to prevent the overshadowing of constitutional considerations. The current framework, as reflected in the Harish Rana judgment, accords significant weight to the opinion of medical boards, often treating their assessments as determinative[18].

A reconceptualised "best interest" standard must clearly distinguish between:

- Clinical facts (diagnosis, prognosis, treatment options)
- Normative judgments (what ought to be done in light of those facts)

Medical professionals are uniquely qualified to provide the former, but the latter must remain within the domain of constitutional reasoning. Courts, therefore, must exercise independent judgment, ensuring that medical opinions inform but do not dictate the outcome.

To achieve this balance, judicial guidelines may be developed to:

- Clarify the evidentiary value of medical reports
- Require explicit reasoning when accepting or departing from expert opinion
- Integrate non-medical considerations into the decision-making process

[18] Harish Rana v. Union of India &Ors. (2026) INSC 222.

Such measures would prevent the "clinicalisation" of constitutional rights and restore the centrality of dignity and autonomy in judicial reasoning.

IV. Towards a Structured "Best Interest" Test

A key limitation of the current doctrine is the absence of a structured methodology for determining best interest. Drawing from both Indian jurisprudence and limited comparative insights, it is possible to outline a more coherent framework that balances flexibility with principled guidance.

A restructured test may include the following sequential considerations:

1. Primacy of Expressed Will: If a valid advance directive exists, it must be given binding effect, subject only to minimal safeguards against coercion or ambiguity.
2. Reconstruction of Presumed Will (Substituted Judgment): In the absence of an advance directive, the court must undertake a detailed inquiry into the patient's likely preferences.
3. Assessment of Medical Condition: Clinical factors, including prognosis and quality of life, should be evaluated as contextual inputs rather than determinative criteria.
4. Balancing of Dignity and Welfare: The final determination must reflect a synthesis of the above elements, with dignity serving as the overarching constitutional value.

This structured approach would not eliminate judicial discretion but would channel it within a principled framework, thereby enhancing consistency and transparency.

V. Institutional and Policy Reforms

Beyond doctrinal refinement, the effective implementation of a reconceptualised standard requires broader institutional support. Legislative intervention may be necessary to codify key aspects of end-of-life decision-making, drawing inspiration from comparative frameworks while adapting them to the Indian context.

Potential reforms include:

- Enactment of a comprehensive law on medical decision-making and patient autonomy
- Establishment of oversight mechanisms to ensure compliance with constitutional standards
- Training programs for medical professionals and judicial officers on ethical and legal dimensions of end-of-life care

Such measures would bridge the gap between judicial pronouncements and practical realities, ensuring that the principles articulated in cases like Common Cause and Harish Rana are effectively translated into practice.

VI. Conclusion: Reclaiming Constitutional Morality at the End of Life

The "best interest" standard, as currently applied in Indian law, reflects a transitional moment in the evolution of end-of-life jurisprudence. It embodies an attempt to reconcile competing values, autonomy, welfare, and institutional responsibility, but falls short of providing a coherent and rights-oriented framework. The Harish Rana case underscores the urgency of this challenge, revealing how doctrinal ambiguity can lead to the persistence of paternalism even within a constitutional order committed to dignity and personal liberty.

A reconceptualised approach, grounded in the primacy of autonomy and supported by structured reasoning and institutional reform, offers a way forward. Such an approach would not only enhance the coherence of the law but also reaffirm the transformative promise of the Constitution, to recognize individuals as agents of their own destiny, even at the threshold of life and death.