

FROM JURISPRUDENTIAL TRIUMPH TO ADMINISTRATIVE GRIDLOCK: A COMPARATIVE CRITIQUE OF SUBSTANTIVE DUE PROCESS AND INSTITUTIONAL COMPETENCE IN INDIA'S AND AMERICA'S "RIGHT TO DIE" JURISPRUDENCE

by

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I. Introduction

The comparative constitutional literature on end-of-life rights has long been organised around a single doctrinal contrast: *Washington v. Glucksberg*,¹ in which the Supreme Court of the United States declined to read a right to physician-assisted suicide into the Due Process Clause of the Fourteenth Amendment, and *Common Cause (A Registered Society) v. Union of India*,² in which the Supreme Court of India held that the right to die with dignity is a facet of the right to life under Article 21. This paper moves past that contrast. Its concern is not whether a court should recognise a right to die, but what follows institutionally once it has recognised or refused to recognise one. The Indian path produced judicially designed administrative machinery that the Court itself modified in 2023 and applied for the first time in March 2026 in *Harish Rana v. Union of India*.³ The American path produced a patchwork of state statutes whose coverage remains geographically fragmented nearly three decades after *Glucksberg*. Comparing these two institutional after-effects, the paper argues that neither judicial recognition nor judicial refusal, standing alone, resolves the execution-stage problem of rights-creation, and it proposes a sunset-limited, dialogic remedial model as a middle path.

II. Two Models of Substantive Due Process: *Glucksberg* and *Common Cause*

In *Washington v. Glucksberg*, the Supreme Court of the United States held that the Due Process Clause of the Fourteenth Amendment does not confer a substantive right to

¹*Washington v. Glucksberg*, 521 U.S. 702, 728 (1997).

²*Common Cause (A Regd. Soc'y) v. Union of India*, (2018) 5 SCC 1 (India).

³*Harish Rana v. Union of India*, 2026 INSC 222 (India).

physician-assisted suicide.⁴ The Court's method was historical and traditionalist: assisted suicide had been disapproved by, and outlawed in, virtually every American jurisdiction for over seven hundred years, and a claimed liberty of this character fails the requirement that a substantive due process right be deeply rooted in the Nation's history and tradition.⁵ Scholars have since made the historical-tradition test itself the subject of sustained critique.⁶ The companion decision in *Vacco v. Quill* rejected the equal-protection theory that treating the withdrawal of life-sustaining treatment differently from assisted suicide is irrational, reasoning that the distinction rests on the long-recognised difference between refusing an unwanted invasion of one's body and a voluntary affirmative act undertaken to hasten death.⁷ Both decisions built upon *Cruzan v. Director, Missouri Department of Health*, which had assumed, without squarely deciding, that a competent person has a liberty interest in refusing unwanted medical treatment while carefully grounding that interest in bodily integrity rather than in any right to hasten death.⁸ The combined doctrinal effect was a deliberate refusal to constitutionalise the right to die at the federal level and a remission of the question to the legislatures of the fifty states.

The Indian Supreme Court travelled the opposite road in stages. In *Gian Kaur v. State of Punjab*, a Constitution Bench held that the right to life under Article 21 does not include a right to die, since the extinguishment of life is inconsistent with the continuum in which the right has meaning, but it expressly left open the distinct question of euthanasia and the withdrawal of treatment in terminally ill circumstances.⁹ *Aruna Ramachandra Shanbaug v. Union of India* then recognised passive euthanasia in a restricted form and instituted judicial supervision of withdrawal decisions through the High Courts.¹⁰ Justice K.S. Puttaswamy (Retd.) v. Union of India consolidated personal autonomy and dignity as core Article 21 content, supplying the doctrinal bridge between the earlier euthanasia cases

⁴Washington v. Glucksberg, 521 U.S. 702, 728 (1997).

⁵Washington v. Glucksberg, 521 U.S. at 710–19 (canvassing centuries of legal prohibitions on assisted suicide).

⁶See Steven G. Calabresi, Substantive Due Process After *Gonzales v. Carhart*, 106 Mich. L. Rev. 1517 (2008); Bryson Jeppesen, The Court as Historian: *Washington v. Glucksberg* and the Right to Die, 4 Princeton Legal J. (Fall 2025).

⁷*Vacco v. Quill*, 521 U.S. 793, 797–802 (1997).

⁸*Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 278–79 (1990).

⁹*Gian Kaur v. State of Punjab*, (1996) 2 SCC 648 (India).

¹⁰*Aruna Ramachandra Shanbaug v. Union of India*, (2011) 4 SCC 454 (India).

and full recognition.¹¹ *Common Cause (A Registered Society) v. Union of India* completed the transition in 2018: a Constitution Bench held that the right to die with dignity is a facet of the right to live with dignity under Article 21, recognised the legality of advance medical directives, and issued detailed operational guidelines for their execution pending legislation.¹² The Court's mode was thus the inverse of *Glucksberg's*: where the American Court declined the right and left implementation to legislatures, the Indian Court recognised the right and retained implementation for itself.

III. The Execution Vacuum: *Common Cause* to Harish Rana

The guidelines issued in *Common Cause* created a wholly judicial administrative apparatus. A request to withdraw life-sustaining treatment required the concurrence of a Hospital Medical Board constituted by the treating hospital and a second Medical Board constituted by the District Collector and chaired by the Chief District Medical Officer, each including specialists of at least twenty years' standing, the approval of the Judicial Magistrate of the first class, and, in the case of advance directives, signature before two attesting witnesses and countersignature by the jurisdictional Judicial Magistrate of the first class.¹³ The structure was criticised as slow, paperwork-intensive, and unrealistic for the hospitals and families it was designed to serve, and commentators warned that its procedural burdens threatened to nullify the substantive right it purported to protect.¹⁴

The practical weight of these requirements fell on a public with little familiarity with the instrument they regulated. A 2019 survey of more than 2,400 respondents found that only 27 per cent had heard of a living will,¹⁵ and later reporting adds that, among those

¹¹Justice K.S. Puttaswamy (Retd.) v. Union of India, (2017) 10 SCC 1 (India).

¹²*Common Cause (A Regd. Soc'y) v. Union of India*, (2018) 5 SCC 1 (India) (laying down procedural guidelines for advance medical directives and the withdrawal of life-sustaining treatment).

¹³*Common Cause (A Regd. Soc'y) v. Union of India*, (2018) 5 SCC 1 (India) (laying down procedural guidelines for advance medical directives and the withdrawal of life-sustaining treatment).

¹⁴Kanwaljit Singh, Case Comment on *Common Cause v. Union of India* (2018), 8 Int'l J. L. Mgmt. & Human. 722 (2025).

¹⁵Only 27% of Indians Aware of Concept of Living Will: Survey, BioSpectrum India (May 8, 2019), <https://www.biospectrumindia.com/news/18/13576/only-27-of-indians-aware-of-concept-of-living-will-survey.html> (last visited Oct. 13, 2026) (reporting a survey of more than 2,400 respondents conducted by Healthcare at Home with the End of Life Care in India Task Force).

aware of the right, only 6 per cent had drafted one.¹⁶ Counsel before the Constitution Bench in January 2023 went further, contending that not a single case had been carried out under the guidelines in the five years since the judgment.¹⁷

In January 2023, a Constitution Bench modified its own guidelines in *Common Cause v. Union of India*.¹⁸ The two-stage board concurrence was retained but shortened, with the Primary and the Secondary Medical Board each expected to give its opinion preferably within forty-eight hours and the minimum experience required of the specialists on each board reduced from twenty years to five; the prior approval of the Judicial Magistrate was replaced by a duty on the hospital to intimate the Magistrate, and the Magistrate's countersignature on advance directives was replaced by attestation before a notary or Gazetted Officer; the mandatory waiting period was dropped where the medical boards concur; and State Governments were directed to consider implementation of the framework. The modification is itself evidence of the pathology this paper identifies: the Court found it necessary to re-open and re-engineer its own administrative machinery within five years of issuing it.

Implementation of the simplified framework has since depended on administrative action in each State. In June 2024 the Bombay High Court criticised the Maharashtra Government for its slow implementation of the Supreme Court's directions on living wills.¹⁹ In January 2025 the Karnataka Health Department issued an order operationalising the framework, reported to make Karnataka the second State after Kerala to do so, under

¹⁶ Vishakha Singhal, *Top India Court Allows Passive Euthanasia, but Few Aware of 'Living Wills'*, Al Jazeera (Aug. 19, 2026), <https://www.aljazeera.com/news/2026/8/19/top-india-court-allows-passive-euthanasia-but-few-aware-of-living-wills> (last visited Oct. 13, 2026) (citing a 2019 survey across seven Indian cities).

¹⁷ Sohini Chowdhury, *Right to Die: How to Make Directions on "Living Will" Workable? Supreme Court Constitution Bench Discusses*, LiveLaw (Jan. 17, 2023), <https://www.livelaw.in/amp/top-stories/right-to-die-how-to-make-directions-on-living-will-workable-supreme-court-constitution-bench-discusses-219231> (last visited Oct. 13, 2026) (recording the submission of Prashant Bhushan).

¹⁸ *Common Cause v. Union of India*, 2023 SCC OnLine SC 99 (India).

¹⁹ O.P. Harsh Singh Munday, *The Legal Journey of Living Wills in India*, SCC Times (May 29, 2025), <https://www.scconline.com/blog/post/2025/05/29/the-legal-journey-of-living-wills-in-india/> (last visited Oct. 13, 2026) (recording the Bombay High Court's criticism in June 2024).

which hospitals must constitute primary and secondary medical boards of three registered practitioners each and send board decisions to the Judicial Magistrate of the First Class.²⁰

The Union executive has also moved without legislating. In September 2024 the Union Health Ministry released draft guidelines for public comment on the withdrawal of life support in terminally ill patients, which treat a severe brain injury with no recovery after seventy-two hours as a terminal condition.²¹ Guidelines of this kind remain administrative directions and do not supply the statutory foundation that the Supreme Court has asked the government to provide in 2018 and again in 2023.²²

Harish Rana v. Union of India supplied the framework's first complete practical application in March 2026. Rana, a thirty-two-year-old man who had remained in a permanent vegetative state for approximately thirteen years following a fall in 2013, was sustained solely by clinically assisted nutrition and hydration delivered through a PEG tube. The Court held that such nutrition and hydration constitutes medical treatment and not mere basic care, and may therefore be withheld or withdrawn under the passive-euthanasia framework where its continuation is not in the patient's best interests.²³ Applying a structured best-interests analysis encompassing medical futility, irreversibility, dignity, and the unanimous views of the medical boards and the family, the Court authorised withdrawal under a palliative and end-of-life care plan at AIIMS, waived the customary thirty-day reconsideration period on the peculiar facts of the case, and issued further streamlining directions: High Courts were instructed to ensure that judicial magistrates receive and process hospital intimations, and the Union Government was directed to ensure that Chief Medical Officers maintain standing panels of registered

²⁰ Chetana Belagere, Karnataka Upholds 'Right to Die with Dignity', in Historic Decision, The South First (Jan. 31, 2025), <https://thesouthfirst.com/news/karnataka-issues-order-upholding-the-right-to-die-with-dignity> (last visited Oct. 13, 2026).

²¹ Health Ministry Issues Draft Guidelines for Withdrawal of Life Support in Terminally Ill Patients, News On AIR (Sept. 30, 2024), <https://www.newsonair.gov.in/health-ministry-issues-draft-guidelines-for-withdrawal-of-life-support-in-terminally-ill-patients> (last visited Oct. 13, 2026).

²² Vishakha Singhal, Top India Court Allows Passive Euthanasia, but Few Aware of 'Living Wills', Al Jazeera (Aug. 19, 2026), <https://www.aljazeera.com/news/2026/8/19/top-india-court-allows-passive-euthanasia-but-few-aware-of-living-wills> (last visited Oct. 13, 2026) (noting that the Supreme Court asked the government to legislate in 2018 and again in 2023).

²³ Harish Rana v. Union of India, 2026 INSC 222 (India) (holding that clinically assisted nutrition and hydration delivered through a PEG tube constitutes medical treatment that may lawfully be withheld or withdrawn under the passive-euthanasia framework).

medical practitioners for nomination to Secondary Medical Boards.²⁴ The Court once again noted the absence of comprehensive legislation and urged Parliament to enact an end-of-life statute.²⁵ Eight years after recognition, the framework's first application still required the Court itself to calibrate the machinery, clarifying the duties of doctors, boards, magistrates and governments in the very order granting relief.²⁶ The Court tied the right to a wider question of access, observing that the right to die with dignity is inseparable from the right to receive quality palliative and end-of-life care.²⁷ That access remains thin: an analysis reported in 2026 estimates that seven to ten million people in India need palliative care while only about four per cent receive it, and Rana himself is reported to have died roughly two weeks after the order.²⁸

IV. The American Patchwork: Legislative Devolution and Its Costs

The recurrence of judicial revision exposes the structural defect more clearly than any single holding. Each modification, the 2023 simplification and the 2026 streamlining directions, was issued by the Court itself, in proceedings that were nominally applications for relief rather than rulemaking. The Court assigned implementation duties to actors who never chose them: hospital boards must give their opinions, preferably within forty-eight hours, Chief Medical Officers must maintain standing panels of practitioners, magistrates must receive and process hospital intimations, and State Governments were directed to consider implementation.²⁹ None of these obligations is traceable to a statute passed by a

²⁴ Advay Vora, In a First, Supreme Court Gives Green Signal for Passive Euthanasia, Supreme Court Observer (Mar. 16, 2026), <https://www.scobserver.in/journal/in-a-first-supreme-court-gives-green-signal-for-passive-euthanasia/> (last visited Oct. 8, 2026).

²⁵ Harish Rana v. Union of India, 2026 INSC 222 (India) (urging Parliament to enact comprehensive legislation on end-of-life decision-making).

²⁶ Raghav Sengupta, Dignity at the End: Analysing the Indian Supreme Court's First Judicially Sanctioned Passive Euthanasia Order, Verfassungsblog (Mar. 28, 2026).

²⁷ Advay Vora, In a First, Supreme Court Gives Green Signal for Passive Euthanasia, Supreme Court Observer (Mar. 16, 2026), <https://www.scobserver.in/journal/in-a-first-supreme-court-gives-green-signal-for-passive-euthanasia/> (last visited Oct. 13, 2026) (quoting the Bench).

²⁸ Vishakha Singhal, Top India Court Allows Passive Euthanasia, but Few Aware of 'Living Wills', Al Jazeera (Aug. 19, 2026), <https://www.aljazeera.com/news/2026/8/19/top-india-court-allows-passive-euthanasia-but-few-aware-of-living-wills> (last visited Oct. 13, 2026) (citing a 2025 analysis in *ecancermedalscience* on palliative care need and reporting Rana's death about two weeks after the order).

²⁹ Advay Vora, In a First, Supreme Court Gives Green Signal for Passive Euthanasia, Supreme Court Observer (Mar. 16, 2026), <https://www.scobserver.in/journal/in-a-first-supreme-court-gives-green-signal-for-passive-euthanasia/> (last visited Oct. 8, 2026).

legislature; all rest on the interpretive authority of a single judgment. The result is a regime whose design authority, amendment authority and adjudicative authority converge in one institution, precisely the configuration the separation of powers exists to guard against.

Glucksberg's refusal produced the outcome its defenders predicted and its critics feared: regulation state by state. Oregon's Death with Dignity Act, approved by ballot measure in 1994 and effective in 1997 after a repeal referendum failed, made Oregon the first American state to legalise medical aid in dying.³⁰ Washington followed by initiative in 2008.³¹ The Oregon regime survived federal challenge in *Gonzales v. Oregon*, where the Supreme Court confirmed that the federal government could not use the Controlled Substances Act to displace a state's medical-practice choices.³² California enacted its End of Life Option Act in 2015, New Jersey followed with its Medical Aid in Dying for the Terminally Ill Act, and New York's Medical Aid in Dying Act took effect on August 5, 2026. As of August 2026, medical aid in dying is lawful in thirteen states and the District of Columbia, by statute or by judicial decision, and remains unauthorised, and in many states expressly prohibited, elsewhere.³³

The pattern is fragmentation rather than coherence. Eligibility criteria diverge across jurisdictions in waiting periods, residency requirements, the number and independence of certifying physicians, and the required proximity of death; Oregon removed its residency requirement by statute in 2023, while other states retain theirs.³⁴ Popular control cuts both ways: Colorado legalised the practice by initiative in 2016, while West Virginia voters approved a constitutional amendment prohibiting assisted suicide in

³⁰Timeline of Death with Dignity in Oregon, Death with Dignity, <https://deathwithdignity.org/states/oregon/> (last visited Oct. 8, 2026).

³¹Assisted Death Policy on the Ballot, Ballotpedia, https://ballotpedia.org/Assisted_death_policy_on_the_ballot (last visited Oct. 8, 2026) (recording the approval of Washington Initiative 1000 in 2008).

³²*Gonzales v. Oregon*, 546 U.S. 243 (2006).

³³Death With Dignity Laws by State, FindLaw, <https://www.findlaw.com/healthcare/patient-rights/death-with-dignity-laws-by-state.html> (last visited Oct. 8, 2026) (reporting thirteen states and the District of Columbia as of August 2026, including New York's Medical Aid in Dying Act, effective August 5, 2026).

³⁴Timeline of Death with Dignity in Oregon, Death with Dignity, <https://deathwithdignity.org/states/oregon/> (last visited Oct. 8, 2026) (recording the 2023 statutory removal of the residency requirement).

2024.³⁵ A terminally ill patient's legal entitlement therefore depends materially on the state in which she resides or to which she can travel. This is the geographic-fragmentation pathology hypothesised above: judicial refusal, unaccompanied by any mechanism compelling national legislative uniformity, did not neutralise the question but dispersed it across fifty differently situated legislatures, leaving access to vary by postcode. Fragmentation operates within legalising States as well as between them. Oregon's official data for 2025 record 400 deaths under its Act, of which only five were of residents of Eastern Oregon, and about half of the attending physicians practised in the three metropolitan counties of Clackamas, Multnomah and Washington.³⁶

V. The Separation-of-Powers Paradox as an Institutional-Competence Question

The consequences of devolution are not limited to substantive divergence; they extend to litigation and access. Because authorisation is a matter of state law, a patient in a prohibiting state has no federal constitutional claim to rely upon, and the only practical remedy is interstate travel to a state that will accept a non-resident, an option most statutes did not contemplate when first enacted and one that presupposes means, mobility and time that terminally ill patients may lack.³⁷ Oregon's most recent official data show the scale of this travel: 37 of the 637 people who received prescriptions in 2025, or six per cent, lived outside the State, up from 24, or four per cent, in 2024.³⁸ Where a few States admit non-residents, the burden of fragmentation is displaced onto patients rather than removed. The devolution model also leaves the deepest questions untouched by any uniform national

³⁵ Assisted Death Policy on the Ballot, Ballotpedia, https://ballotpedia.org/Assisted_death_policy_on_the_ballot (last visited Oct. 8, 2026) (recording the approval of Colorado Proposition 106 in 2016 and of West Virginia's 2024 amendment prohibiting assisted suicide).

³⁶ Or. Health Auth., Pub. Health Div., Ctr. for Health Stat., 2025 Oregon Death with Dignity Act Data Summary (2026), <https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/Documents/year28.pdf> (last visited Oct. 13, 2026) (reporting deaths by county of residence and the practice location of attending physicians).

³⁷ Timeline of Death with Dignity in Oregon, Death with Dignity, <https://deathwithdignity.org/states/oregon/> (last visited Oct. 8, 2026) (recording the 2023 statutory removal of the residency requirement).

³⁸ Or. Health Auth., Pub. Health Div., Ctr. for Health Stat., 2025 Oregon Death with Dignity Act Data Summary (2026), <https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/Documents/year28.pdf> (last visited Oct. 13, 2026) (reporting prescription recipients who lived outside Oregon).

floor: there is no federal statute on medical aid in dying, and the Supreme Court has not revisited Glucksberg. Judicial restraint at the recognition stage thus did not depoliticise the question; it redistributed it to the level of government least able to guarantee uniformity of entitlement across the nation.

Bickel's countermajoritarian difficulty frames the orthodox American justification for the Glucksberg result: where the Constitution does not speak clearly, courts should decline to constitutionalise contested policy and leave it to the representative branches.³⁹ On that view, Glucksberg is judicial restraint in its most orthodox form, and the resulting patchwork is federalism working as designed. But the countermajoritarian framing addresses only the recognition stage of a right's life. It is silent about the execution stage, which is where the Indian difficulty lies.

The Least Examined Branch literature re-centres legislatures as constitutional actors whose absence from a rights-creation process is itself analytically significant.⁴⁰ Indian scholarship sharpens the point from the other direction. Sathe documented the expansion of judicial power into domains of policy without a corresponding institutional capacity to administer what the courts create.⁴¹ Bhuwania has shown how public interest litigation converts broad constitutional pronouncements into continuing, court-managed regulatory regimes with unstable boundaries.⁴² Common Cause is a textbook instance: the Court did not merely declare a right; it constituted boards, specified timelines, assigned roles to magistrates and Chief Medical Officers, and then revisited its own scheme in 2023 and again in 2026. The paradox is symmetrical. The American model's restraint at the recognition stage produced administrative diffusion; the Indian model's engagement at that stage produced administrative absorption. Each model exports the execution problem to the institution least equipped, on the record examined here, to resolve it.

³⁹Alexander M. Bickel, *The Least Dangerous Branch: The Supreme Court at the Bar of Politics* (2d ed. Yale Univ. Press 1986).

⁴⁰Richard W. Bauman & Tsvi Kahana eds., *The Least Examined Branch: The Role of Legislatures in the Constitutional State* (Cambridge Univ. Press 2006).

⁴¹S.P. Sathe, *Judicial Activism in India: Transgressing Borders and Enforcing Limits* (2d ed. Oxford Univ. Press 2002).

⁴²Anuj Bhuwania, *Courting the People: Public Interest Litigation in a Post-Emergency India* (Cambridge Univ. Press 2017).

VI. Living-Wills Theory Versus Institutional Reality in India

The comparison also exposes the limits of treating institutional competence as a unitary concept. The competence question is not a single binary of court versus legislature but varies with the stage of a right's life and the kind of decision required. At the stage of principle, whether a person may refuse treatment or obtain aid in dying, courts can articulate constitutional values, and the Indian Court's recognition of dignity-based autonomy is defensible on orthodox Article 21 reasoning. At the stage of machinery, however, competence attaches to the institution with statutory rulemaking capacity, administrative infrastructure and political accountability: a legislature. Common Cause performed both stages itself, and the sequel through 2026 shows the second stage steadily displacing the first. An adequate separation-of-powers account of rights-creation must therefore distinguish the declaratory function, which courts may properly retain, from the constitutive function of building administrative machinery, which they cannot discharge without becoming continuing regulators of the very domain they adjudicate.

The autonomy case for advance directives is strongest in theory and most fragile in practice. A directive made by a competent person operates precisely because its maker may later become incompetent; its value therefore depends entirely on the reliability of the machinery that verifies, stores, and executes it. Common Cause recognised directives but wrapped them in attestation, registration and magistrate countersignature requirements that commentators described as capable of deterring the very autonomy the right was meant to serve.⁴³ The 2023 modification eased the burdens, but the supporting infrastructure, namely directives actually registered, boards actually convened within forty-eight hours, and magistrates actually available, remains substantially untested at scale.

Harish Rana illustrates the gap between recognition and usable entitlement from the other end. The case involved no advance directive at all: the application was made by next of kin on behalf of a patient incompetent since 2013, and the process consumed years of litigation, including a rejected petition before the Delhi High Court in 2024, before

⁴³Kanwaljit Singh, Case Comment on Common Cause v. Union of India (2018), 8 Int'l J. L. Mgmt. & Human. 722 (2025); A. Anusree, K. Gopalan & G.A. Prakash, Exploring Euthanasia: A Comparative Legal Analysis of India's Constitutional Approach and Global Practices, J. Pioneering Med. Sci. (2025).

reaching the Supreme Court.⁴⁴ If the framework's first complete application required the apex Court's personal supervision, the anticipated volume of routine cases cannot plausibly be serviced by judicial attention of that intensity. The directions in Harish Rana to maintain Chief Medical Officer panels and to standardise magistrate handling are judicial micro-management of administrative design, however well-intentioned; they confirm the diagnosis of continuing judicial regulatory entanglement rather than rebutting it.

Early commentary on Harish Rana makes a related point from a rights perspective. It observes that the judgment sets no clear evidentiary thresholds or ordering among the best-interests factors, does not require independent psychological or social-work assessment of families who may be under economic strain, and engages only lightly with disability-rights frameworks. It argues that, in the absence of legislation, the Court's guidelines now operate as law without legislative scrutiny.⁴⁵

VII. Toward a Comparative Framework and Remedial Model

The magistrate countersignature requirement illustrates the design failure in miniature. A directive whose principal function is to speak for a person who may become incompetent within hours cannot rationally depend on a judicial formality that few ordinary citizens can readily complete, and the requirement served no evidentiary purpose that attestation before a notary or Gazetted Officer could not serve better. Its removal in 2023 was an implicit judicial acknowledgment that the original design mistaken administrative formality for substantive safeguard. The deeper point is that such errors are not incidental drafting mistakes; they are the predictable product of a court designing medical administration without legislative hearing, sectoral expertise or the capacity to pilot and revise a scheme through administrative channels. The correction loop, when it exists at all, runs through litigation, which is slow, party-driven and case-bound, rather than through the routine machinery of regulatory revision. By contrast, where a legislature owns the scheme,

⁴⁴Supreme Court Allows 1st Passive Euthanasia in Harish Rana Case, Drishti IAS, <https://www.drishtias.com/daily-updates/daily-news-analysis/sc-allows-1st-passive-euthanasia-in-harish-rana-case> (last visited Oct. 8, 2026) (recording the dismissal of the family's plea by the Delhi High Court in 2024).

⁴⁵ Raghav Sengupta, Dignity at the End: Analysing the Indian Supreme Court's First Judicially Sanctioned Passive Euthanasia Order, Verfassungsblog (Mar. 28, 2026), <https://verfassungsblog.de/harish-rana-v-union-of-india/> (last visited Oct. 13, 2026).

the evidence base is refreshed routinely: Oregon's health authority publishes an annual data summary of how its statute is used, and the 2025 edition records, for example, that 155 physicians wrote the 637 prescriptions and that 91.8 per cent of those who died were enrolled in hospice.⁴⁶ Information of this kind lets a legislature or regulator revise a scheme without waiting for a litigant to reach court.

The comparison suggests a typology of rights requiring ongoing administration, organised around three variables: the technicality of the operational content a right requires, the irreversibility of error in its execution, and the scarcity of the institutional capacity needed to deliver it. A right whose content is self-executing, such as the privacy interests recognised in *Puttaswamy*, generates little entanglement: courts articulate the principle and withdraw. A right whose execution demands medical protocols, multi-member boards, statutory timelines and death itself as the outcome scores high on all three variables and generates maximal entanglement, as the Indian record from 2018 to 2026 demonstrates. *Glucksberg* avoided that entanglement by refusing the right, but scored no better on outcomes, because refusal devolved the same technical questions to fifty legislatures of unequal capacity and uneven will.⁴⁷

The remedial implication is a middle path. A court that recognises a right of this type should issue its implementation guidelines on an express sunset of, say, eighteen to twenty-four months, and simultaneously make a mandatory legislative reference directing the appropriate legislature to enact the operative machinery within that period, with the guidelines continuing in force until the legislature acts and the Court retaining jurisdiction to review the statutory substitute. The model preserves the substantive gain of *Common Cause*, avoids the constitutionalising court's indefinite administration of medical practice, and answers the fragmentation objection to *Glucksberg* by compelling a single legislative response rather than fifty. It accepts that judicially fixed time-limits cannot bind a legislature in the fullest sense; their function is dialogic, converting a one-time declaration

⁴⁶ Or. Health Auth., Pub. Health Div., Ctr. for Health Stat., 2025 Oregon Death with Dignity Act Data Summary (2026), <https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/Documents/year28.pdf> (last visited Oct. 13, 2026) (reporting prescribing physicians and hospice enrolment).

⁴⁷ See Penney Lewis, *Assisted Dying and Legal Change* (Oxford Univ. Press 2007) (arguing that the legal route to a right, rather than only its substantive content, shapes the resulting regulatory regime).

into a structured conversation whose default outcome is statutory ownership of machinery that courts are ill-suited to run indefinitely.

VIII. Conclusion

Neither Washington nor New Delhi has solved the execution-stage problem of right-to-die jurisprudence; each has demonstrated a different way of failing it. The United States obtained doctrinal modesty at the price of geographic fragmentation that persists after nearly three decades, thirteen states and the District of Columbia acting by statute or judicial decision while most states continue to prohibit the practice. India obtained substantive recognition at the price of durable judicial administrative entanglement: guidelines designed in 2018, re-engineered in 2023, and applied and clarified in a single case in 2026, with the underlying legislation still absent and Parliament having been urged, again, to act. The lesson is not that courts should refuse to act or that they should administer what they create. It is that the doctrinal route to a right determines the institutional location of its design burden, and that a court which recognises a right requiring ongoing administration should design its remedy to terminate, by sunset and mandatory legislative reference, in the institution competent to run it. The comparative record examined here supplies the beginnings of that framework, and the pending legislative response to Harish Rana will supply its next test.

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