
HARISH RANA V. UNION OF INDIA (2026 INSC 222): OPERATIONALISING PASSIVE EUTHANASIA UNDER ARTICLE 21'S RIGHT TO DIE WITH DIGNITY

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ABSTRACT

The decision of the Supreme Court in *Harish Rana v. Union of India* (2026 INSC 222), delivered on 11 March 2026 by Justices J.B. Pardiwala and K.V. Viswanathan, represents the first full judicial implementation of the passive euthanasia framework evolved in *Common Cause v. Union of India* (2018) 5 SCC 1. The Court permitted the withdrawal of Clinically Assisted Nutrition and Hydration (CANH) administered through a PEG tube to a patient who had remained in a permanent vegetative state (PVS) since 2013. In doing so, the Court unequivocally held that CANH constitutes a form of medical treatment capable of lawful withdrawal where continuation no longer serves the patient's best interests. The judgment significantly advances Article 21 jurisprudence by reaffirming that the right to life includes the right to die with dignity in narrowly circumscribed circumstances involving medical futility and irreversible suffering. It further refines the "best interests" doctrine through a dual medical board mechanism, mandates palliative and end-of-life care, and streamlines procedural safeguards for patients receiving home-based care. This article critically examines the constitutional reasoning, ratio decidendi, doctrinal evolution, and the broader implications of the judgment for Indian constitutional, medical, and end-of-life care jurisprudence.

Keywords: Passive Euthanasia, Article 21, Right to Die with Dignity, CANH, Permanent Vegetative State, Best Interests Test, Medical Boards

1. Introduction

The constitutional discourse surrounding the right to life under Article 21 of the Constitution of India has progressively expanded beyond mere biological existence to include the protection of dignity, autonomy, and humane treatment. The jurisprudential journey from *P. Rathinam v. Union of India*¹ to *Gian Kaur v. State of Punjab*² and ultimately to *Common Cause v. Union of India*³ reflects a gradual judicial recognition that dignity must accompany life until its natural end.

While *Common Cause* established the constitutional legitimacy of passive euthanasia and advance medical directives, its practical implementation remained largely untested. In this context, *Harish Rana v. Union of India*⁴ assumes exceptional significance. The judgment transforms previously articulated constitutional principles into an enforceable legal framework by authorising the withdrawal of life-sustaining treatment in an irreversible PVS case.

The decision marks a decisive shift from abstract recognition of dignified dying to the actual judicial operationalisation of end-of-life autonomy. It strengthens the constitutional understanding that Article 21 protects not merely the continuation of life, but life with dignity, including the dignity of the dying process.

2. Facts of the Case

Harish Rana, a B.Tech student at Panjab University, sustained severe neurological injuries following a fall from the fourth floor of his accommodation on 20 August 2013.⁵ The incident resulted in diffuse axonal injury, quadriplegia, and a prolonged permanent vegetative state.

He underwent treatment at PGI Chandigarh, AIIMS New Delhi, Dr. Ram Manohar Lohia Hospital, and Safdarjung Hospital. Over time, a PEG tube was inserted to administer Clinically Assisted Nutrition and Hydration (CANH), and

¹ (1994) 3 SCC 394.

² (1996) 2 SCC 648.

³ (2018) 5 SCC 1.

⁴ 2026 INSC 222.

⁵ *ibid.*

he remained entirely dependent on medical intervention for sustenance.⁶

Medical evidence consistently established that he suffered from 100% permanent disability, had no cognitive awareness, and possessed no realistic prospect of neurological recovery. Following years of continuous medical care, recurrent hospitalisations, and complete dependency, his family approached the Supreme Court seeking withdrawal of life-sustaining treatment in accordance with the framework laid down in *Common Cause*.⁷

Pursuant to judicial directions, both the Primary Medical Board and the Secondary Medical Board unanimously concluded that Harish Rana was in an irreversible permanent vegetative state and that continuation of CANH served no therapeutic purpose beyond the artificial prolongation of biological existence.⁸

3. Legal Issues Involved

The principal legal issues before the Court were:

1. Whether CANH administered through a PEG tube constitutes “medical treatment” capable of lawful withdrawal;
2. Whether passive euthanasia is permissible in the absence of an advance medical directive;
3. Whether continued life-sustaining treatment in the present case violated the dignity component of Article 21;
4. Whether the continuation of treatment remained in the patient’s best interests;
5. What procedural safeguards must govern the withdrawal of such treatment.

4. Arguments and Judicial Reasoning

The petitioners contended that the Delhi High Court had erred in treating the absence of mechanical ventilation as decisive. They argued that artificial nutrition and hydration through a PEG tube is a medically supervised invasive intervention and therefore falls within the ambit of life-sustaining treatment.⁹

The Supreme Court accepted this submission. Justice Pardiwala, speaking for the Bench, drew a clear doctrinal distinction between active and passive euthanasia. The Court reiterated that active euthanasia involves a positive act causing the intentional death of a person by direct intervention and remains legally impermissible in the absence of valid legislative sanction. By contrast, passive euthanasia entails the withholding or withdrawal of life-sustaining medical treatment where such treatment has become medically futile, thereby allowing the natural process of death to take its course in a dignified manner. The present case was held to fall squarely within the latter category.¹⁰

The Court held that CANH is not equivalent to ordinary feeding or basic caregiving. Instead, it is a medically administered invasive procedure requiring clinical supervision and is therefore properly classifiable as medical treatment. In arriving at this conclusion, the Court relied upon comparative jurisprudence including *Airedale NHS Trust v Bland*¹¹ and reaffirmed the principles laid down in *Common Cause*.

A significant doctrinal contribution of the judgment lies in its reformulation of the inquiry. The Court held that the correct legal question is not whether death is in the patient’s best interests, but whether the continued artificial prolongation of life remains in the patient’s best interests.¹²

This shift in framing strengthens the jurisprudential coherence of passive euthanasia law.

5. Ratio Decidendi and Obiter Dicta

Ratio Decidendi

The ratio decidendi of the judgment may be distilled into the following propositions of law:

- Clinically Assisted Nutrition and Hydration (CANH) administered through a PEG tube constitutes medical treatment and not mere ordinary care;

⁶ *ibid.*

⁷ *ibid.*

⁸ *ibid.*

⁹ Law Commission of India, 241st Report on Passive Euthanasia (2012).

¹⁰ Harish Rana (n 4).

¹¹ *Airedale NHS Trust v Bland* [1993] AC 789 (HL).

¹² Harish Rana (n 4).

- such treatment may be lawfully withdrawn where the Primary and Secondary Medical Boards unanimously conclude that its continuation is medically futile and serves no therapeutic purpose;
- the withdrawal of such treatment is constitutionally permissible where continued artificial prolongation of life no longer serves the patient's best interests and undermines dignity protected under Article 21 of the Constitution;
- passive euthanasia is legally permissible even in the absence of an advance medical directive, provided that the procedural safeguards laid down in *Common Cause v Union of India* are strictly complied with.¹³

Obiter Dicta

The Court's observations urging Parliament to enact a comprehensive statutory framework governing end-of-life care, passive euthanasia, advance medical directives, and substitute decision-making constitute highly persuasive obiter dicta. The Bench expressly acknowledged that judicial guidelines, however necessary, cannot serve as a permanent substitute for legislative intervention.¹⁴

6. Constitutional and Statutory Analysis

The judgment is firmly rooted in Article 21 of the Constitution.

Beginning with *Maneka Gandhi v. Union of India*¹⁵, Article 21 has been interpreted expansively to include dignity as an intrinsic constitutional value. This interpretive trajectory was further developed in *Gian Kaur* and subsequently constitutionalised in *Common Cause*.

In *Harish Rana*, the Court deepens this doctrine by affirming that dignity extends not merely to the conditions of living but also to the process of dying. The right to life under Article 21 therefore includes the right to avoid futile and medically burdensome prolongation of

existence in cases of irreversible PVS.

The judgment also exposes a significant statutory vacuum. India continues to lack a comprehensive legislative framework governing passive euthanasia, living wills, substitute consent, and end-of-life care. Consequently, the Court has once again been compelled to fill the normative gap through constitutional adjudication.

7. Critical Analysis of the Judgment

The judgment in *Harish Rana v Union of India* is notable for its doctrinal precision as well as its humanitarian sensitivity. At the outset, the Court resolves a long-standing ambiguity in Indian end-of-life jurisprudence by expressly holding that Clinically Assisted Nutrition and Hydration (CANH) constitutes medical treatment rather than ordinary care, thereby bringing it squarely within the scope of lawful withdrawal under the *Common Cause* framework.

Secondly, the Court's articulation of the "best interests" test is jurisprudentially sophisticated and closely aligned with comparative common law standards. By requiring a holistic assessment that includes medical futility, preservation of dignity, emotional welfare, and the considered views of the patient's family, the Court moves beyond a purely clinical inquiry and adopts a more constitutionally grounded approach to end-of-life decision-making.

Thirdly, the procedural refinements introduced for home-care patients and the constitution of dual medical boards significantly enhance the practical workability of the *Common Cause* guidelines. In this respect, the judgment succeeds in transforming a previously abstract constitutional framework into an enforceable legal process.

However, certain concerns persist. The continued absence of a comprehensive statutory framework leaves substantial room for inconsistency in implementation across states, particularly in rural and semi-urban areas where access to specialised medical boards, tertiary

¹³ *ibid.*

¹⁴ *ibid.*

¹⁵ (1978) 1 SCC 248.

medical institutions, and palliative care facilities remains limited. Further, the law governing disputed family consent and substitute decision-making remains insufficiently developed and calls for legislative clarification.

The lack of comprehensive legislation also poses continuing legal and institutional risks for doctors and hospital staff. In the absence of a clear statutory shield, medical professionals may remain apprehensive about potential civil, criminal, or disciplinary consequences arising from the withdrawal of life-sustaining treatment, despite judicial guidelines. Such uncertainty may discourage timely medical decision-making and undermine the effective implementation of the right to die with dignity. The judgment therefore not only advances Article 21 dignity jurisprudence but also underscores the urgent need for comprehensive parliamentary legislation on end-of-life care, both to protect patient autonomy and to provide legal certainty for healthcare professionals.

8. Comparison with Previous Landmark Cases

The evolution of India's euthanasia jurisprudence reflects a carefully calibrated three-stage progression: *Aruna Ramachandra Shanbaug v Union of India*¹⁶ laid the foundational recognition of passive euthanasia in India, although the Court declined to grant relief on the facts after holding that the petitioner was not the appropriate "next friend", which status it instead vested in the KEM Hospital staff who opposed the withdrawal of treatment. This initial judicial caution subsequently gave way to constitutional affirmation in *Common Cause v Union of India*¹⁷, where a Constitution Bench elevated the right to die with dignity into an integral facet of Article 21 and laid down a comprehensive procedural framework through advance medical directives and medical boards. *Harish Rana v Union of India*¹⁸ consummates this doctrinal trajectory as the first full

operationalisation of the Common Cause framework in the absence of an advance directive. Whereas Aruna laid the foundation and Common Cause erected the constitutional architecture, Harish Rana gives these principles concrete legal application by classifying CANH as withdrawable medical treatment and refining procedural safeguards for home-care patients. Taken together, these decisions trace the evolution of Article 21 dignity jurisprudence from tentative recognition to enforceable constitutional reality.

9. Impact on Indian Constitutional Jurisprudence

The judgment significantly strengthens dignity-based constitutional interpretation under Article 21. It firmly establishes that the principle of sanctity of life cannot be invoked mechanically to justify the medically futile prolongation of biological existence. Instead, the Court places human dignity at the centre of constitutional analysis, thereby reaffirming dignity as the controlling constitutional value in end-of-life jurisprudence.

The decision is likely to have far-reaching implications for future constitutional and medical law adjudication, particularly in relation to advance medical directives (living wills), substituted consent, palliative and end-of-life care rights, medical negligence in treatment-withdrawal cases, and broader questions of personal autonomy and bodily integrity under Article 21 of the Constitution.

More significantly, the judgment deepens the jurisprudential shift from a purely life-preservative approach toward a dignity-oriented constitutional framework, where the quality, meaning, and conditions of continued existence become legally relevant considerations.

10. Conclusion

*Harish Rana v Union of India*¹⁹ consummates the evolution of Article 21 by extending the constitutional guarantee of the right to life into the realm of dignified dying. Through the

¹⁶ (2011) 4 SCC 454.

¹⁷ Common Cause (n 3).

¹⁸ Harish Rana (n 4).

¹⁹ *ibid.*

constitution of dual medical boards certifying the futility of Clinically Assisted Nutrition and Hydration (CANH), coupled with the mandatory provision of palliative and end-of-life care, the Supreme Court has transformed the constitutional framework articulated in Common Cause into enforceable legal reality, thereby effectively bridging constitutional theory with medical practice.

At the same time, the judgment exposes the limitations of continued judicial interim arrangements in the absence of a comprehensive statutory framework. The Court's repeated appeals for legislative intervention, echoing the concerns articulated in the 196th and 241st Reports of the Law Commission of India, underscore Parliament's constitutional responsibility to enact a robust and comprehensive legal regime governing end-of-life care, advance medical directives, substituted consent, and passive euthanasia.

As the Court itself observed, the decision is not about choosing death, but about not artificially prolonging life where treatment no longer heals, restores, or meaningfully improves life.²⁰

From Aruna Ramachandra Shanbaug's foundational caution, through Common Cause's constitutional architecture, to Harish Rana's compassionate implementation, Article 21 now unequivocally protects dignity not merely in living, but also up to the end of natural life and in the dignified process of dying.

²⁰ (2026 INSC 222) para 332.