HARISH RANA V. UNION OF INDIA 2026: A CRITICAL ANALYSIS OF THE JUDICIAL EVOLUTION OF PASSIVE EUTHANASIA IN INDIA

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ABSTRACT

In the judgment of *Harish Rana v. Union of India (2026)*[1] delivered by J.B. Pardiwala and K.V Visvanathan, the Supreme Court, for the first time, permitted the withdrawal of life-sustaining medical treatment CANH, without an executed Advance Medical Directive AMD. Unlike active euthanasia, which remains categorically prohibited in India as it constitutes an offence under the Indian Penal Code, Passive euthanasia, the withdrawal or withholding of life-sustaining treatment, has gradually gained judicial recognition as a legitimate exercise of the right to die with dignity under Article 21.

This Article analyses the reasoning and ratio decidendi of Harish Rana, a judgment that has evolved through a series of landmark judicial pronouncements, wherein the Supreme Court drew observations significantly from foreign jurisdictions including the decision in *Airedale NHS Trust v. Bland*[2], the New Zealand judgment in *Auckland Area Health Board*[3] and comparative perspective from the United States and Europe, to inform its reasoning on withdrawal or withholding of life-sustaining treatment. This comparative judicial exercise culminated in *Common Cause v. Union of India (2018)*[4], setting a binding precedent that legalized passive euthanasia in India. Yet there remains a structural vulnerability which should be addressed through a legislative statutory framework that translates judicial guidelines into enforceable legal rights.

This Article critically examines whether the judicial framework governing passive euthanasia in India, as it stands, is sufficient to guarantee the right to die with dignity or whether the absence of legislative intervention leaves this right structurally fragile.

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1 *Harish Rana v. Union of India*, 2026 INSC 222.
2 *Airedale NHS Trust v. Bland,* [1993] AC 789 (HL).
3 *Auckland Area Health v. Attorney-General,* [1993] 1 NZLR 235.
4 *Common Cause (A Regd. Society) v. Union of India, (2018*) 5 SCC 1.

FACTS OF THE CASE

Harish Rana, the applicant, was pursuing B. Tech at Punjab University. On the evening of 20/08/2013, Harish fell from the 4th floor of his accommodation, as a result, he sustained a Diffuse Axonal Injury. He remained admitted in the hospital from 21/08/2013 to 27/08/2013, where he was administered treatment in the form of AED, analgesics, ventilating support, antibiotics, tracheostomy, and feeding through Ryle's tube. Following his discharge, his health did not improve and kept deteriorating. The mode of administering Clinically Assisted Nutrition and Hydration, CANH, was now switched from Ryle's tube to a surgically placed PEG tube. As per medical evidences, Harish suffered from 100% permanent disability, he had no cognitive awareness, and was in a persistent vegetative state, PVS. Following his complete dependency, medical care, and frequent hospitalisation, the family of Harish approached the Supreme Court in the year 2025 for withdrawal of life-sustaining treatment in accordance with guidelines laid down in *Common Cause.* On the appointment of the primary and secondary medical board, it was stated that the patient is in a permanent vegetative state and his recovery is negligible. The family of Harish stated that after the years of exhaustive efforts and prolonged medical treatment, which did not contribute to any improvement in his health, they appealed for discontinuation of his medical treatment which had been imparted over 13 years and let nature take its course.

ISSUES CONSIDERED BY THE SUPREME COURT

1. Whether the administration of CANH be regarded as medical treatment
2. What is the best interest of the patient in the determination of withdrawal or withholding of medical treatment
3. Is it in the best interest of the applicant that his life be prolonged by continuation of medical treatment?

REASONING OF THE COURT

In addressing the issues, the Supreme Court holds that CANH constitutes 'medical treatment' and must be governed by the same legal principles applicable to the withholding or withdrawal of other forms of life-sustaining medical interventions, subject, of course, to the safeguards and

procedural requirements laid down by this Court in *Common Cause vs. Union of India (2018)*[5], and with reference to the judgment of High Court of Auckland, New Zealand in *Auckland Area Health Board v. Attorney-General reported in (1992)*, Lord Keith's observations in Airedale, reasoning of Morris J., as recognised by the Supreme Court of Victoria, Australia.

Secondly, the Court firmly holds the principle of "best interest of the patient" while considering both subjective and objective views. patient's next of kin/next friend/guardian, the medical boards, or the courts (if involved), while determining what constitutes the best interests of the patient. Under Article 21 of the Indian Constitution, every person has the right to life and to personal autonomy over medical decisions. However, if a person is in a PVS, their medical treatment can be discontinued on their behalf according to the guidelines upheld in *Common Cause* (2018), both medical as well as non-medical considerations ought to be given due weightage and be considered as a part of the governing principle of best interest.

FROM ARUNA SHANBAUG TO COMMON CAUSE GUIDELINES

In the case of *Aruna Shanbaug v. Union of India*[6], as per the judgment of the Supreme Court, Aruna was in a Persistent Vegetative State, (PVS) even though she was not brain dead and She could breathe completely on her own without a ventilator, could swallow mashed food, and reacted to certain sensory stimuli like loud noises, pain, and her favourite songs. The Supreme Court emphasized that there was no locus standi in this case. The Supreme Court endorsed the recommendation of the team of doctors that the dean was best placed to decide on the euthanasia plea as Aruna's next friend, since KEM hospital staff had taken care of her for decades when her family abandoned her. This was the very first time the question of passive euthanasia was to be decided by the court. The Supreme Court chose to go beyond its call of duty by deciding on the larger question: should euthanasia be permissible at all in India, and if so, under what circumstances? This Hon'ble court opined that there is no statutory provision in our country as to the legal procedure for withdrawing life support to a person in PVS or who is otherwise incompetent to make a decision in this connection. The court further opined that passive euthanasia should be permitted in our country in certain situations, following the judicial technique employed in *Vishaka v. State of Rajasthan*[7], whereby the court issued binding guidelines to fill a legislative vacuum, adopting the same approach. This Court laid

[5] *Common Cause* supra (n 4).
[6] *Aruna Shanbaug v. Union of India,* (2011) 4 SCC 454.
[7] *Vishaka v. State of Rajasthan,* (1997) 6 SCC 241.

down a procedural framework for passive euthanasia until Parliament legislates. The model included appointing a team of doctors (comprising a neurologist, psychiatrist, and a physician) to report to the court, issue notice to the state and close relatives of the patient, and so on. It would ultimately be up to the court to determine if the case was fit for permitting passive euthanasia, after considering doctor's reports and the next friend's opinion.

In the case of Gian *Kaur v. State of Punjab*[8] (1996), the Supreme Court held that 'right to die' is not included in fundamental right under article 21 'right to life', but crucially noted that a terminally ill patient in a permanent vegetative state has the right to a dignified death process, this judgment opened a window of opportunity to legalise euthanasia within existing legal framework. In the case of Aruna, the Supreme Court recognized passive euthanasia without grounding it in the 'right to die with dignity'. Thus, the *Common Cause* (2018) constitutional bench stepped in to fill the lacuna left. *Common Cause* (2018) recognised 'right to die with dignity' as a fundamental right under Article 21, 'right to life', and validated Advance Medical Directives (Living Wills).

The framework establishes a two-tier mechanism: adults of sound mind can voluntarily execute a 'living will' specifying that medical treatment be refused or withdrawn if they fall terminally ill and or in irreversible comatose. The document should be signed by the executor in the presence of two attesting witnesses and countersigned by JMFC. The instruction given in the document must be given due weight by the doctors. However, it should be given effect to only when the doctor is fully satisfied that the executor is terminally ill and that the illness is incurable or there is no hope of his/her being cured. The hospital where the executor has been admitted shall then constitute a Hospital Medical Board consisting of the head of the treating department and at least three expert doctors who in turn shall visit the patient in the presence of his close relative and then form an opinion which will be regarded as a preliminary opinion. The JMFC shall then immediately constitute a Medical Board. before giving the decision, the JMFC shall visit the patient and after examining all aspects authorise the implementation of the decision of the Board. If the permission to withdraw medical treatment is refused by the Medical Board, it would be open to the family members to approach the High Court by the way of writ petition under Article 226.

In cases where there is no Advance Directive, the procedure and safeguard are the same as

[8] *Gian Kaur v. State of Punjab,* (1996) 2 SCC 648.

applied to cases where Advance Directives are in existence. In cases where passive euthanasia becomes applicable as a situational palliative measure, the court held that the best interest of the patient shall override the state's interest in preserving life. The judgment in the case of *Common Cause* (supra) sets a prominent precedent in deciding the cases of passive euthanasia in the future. Where the autonomy of the patient and his best interest are taken into consideration. However, it bears noting that this elaborative procedure, while well-intentioned as a safeguard against misuse, has drawn criticism for creating bureaucratic delays in time sensitive end of life situations. The Supreme Court itself acknowledged these concerns and subsequently simplified the procedure in 2023, reflecting the practical tension between institutional safeguard and the very dignity it seeks to protect.

RIGHT TO LIFE & RIGHT TO DIE WITH DIGNITY

Is it constitutionally permissible to penalize suicide? This question arose in the Supreme Court, wherein P. Rathinam and Nag Bhushan Patnaik filed two Writ Petitions under Article 32 of the Constitution. The writ petitions assailed the constitutional validity of Section 309 of the Indian Penal Code (IPC), contending that the same is violative of Articles 14 and 21 of the Constitution. The Supreme Court approved the view taken by the Bombay High Court in the case of *Maruti Shripati Dubal v. State of Maharashtra*[9], wherein it held that, as every article has its own positive and negative arena, that is, freedom of speech and expression also contains the right not to speak, similarly, freedom for movement and association also includes freedom not to join any association. Eventually, it concluded that the right to life of which Article 21 speaks of can be said to bring in its trail the right not to live a forced life, and the Court also affirmed that every man is the master of his own body and has the right to deal with it as he pleases.

The judgment of P. Rathinam, while philosophically appealing, created serious doctrinal inconsistencies in criminal and constitutional law simultaneously. It raised a question that the court had not anticipated: if every person has the right to die, does that include the absolute right to end life not just in terminal illness but in depression, financial ruin, etc. without seeking any preventive measures and help, does right to die mean an abetment to die is also legalized, does recognizing right to die not directly contradict section 306 IPC.

[9] *Maruti Shripati Dubal v. State of Maharashtra,* 1987 SCC OnLine Bom 95.

The Supreme Court judgment in P. Rathinam did not hold for long. In *Gian Kaur* (supra), the Court overruled its earlier judgment and held afresh that the constitutional right to life did not include the right to die. 'Right to Life' is a natural right embodied in Article 21, but suicide is an unnatural extinction or termination of life and therefore inconsistent with the concept of 'right to life'.

However, *Gian Kaur (supra*) also opened a window of opportunity to legalise passive euthanasia. The Court held that though the right to life did not include the right to die, it did encompass the 'right to die with dignity'. However, the right to die with dignity cannot be confused with the right to die an unnatural death. In persons who are terminally ill or in a vegetative state and are in an incurable state, death has already commenced in these patients, but are kept alive through technological intervention. Death, in such cases, is an ongoing process being interrupted by technological intervention wherein the dignity of the patient is being compromised, and whether the medical treatment can be lawfully withdrawn or withheld where the medical profession has already determined the condition of the patient is irreversible.

It was with this precise category of patients, those who were in a vegetative state or terminally with no prospect of recovery, that the Constitutional Bench in *Common Cause (supra)* sought to address by recognizing the right to die with dignity. As an enforceable fundamental right under Article 21.

RATIO DECIDENDI AND GAPS LEFT IN THE JUDGMENT

Ratio decidendi established by the court is as follows: As CANH requires medical intervention, Administration of CANH should be treated as medical treatment as opposed to being regarded as basic primary care; that the withdrawal or withholding of such treatment would be permissible and amenable to the same principles governing the withdrawal or withholding of any other form of medical treatment. The continued administration of CANH is required for the sustenance of his survival. However, the same may not aid in improving his condition or repairing his underlying brain damage. The withdrawal of CANH would hasten death, but held that this does not transform the act into active euthanasia, the cause of death remains the underlying irreversible condition, not the withdrawal itself. The administration of CANH at home does not displace the status of such CANH as being considered a medical treatment.

Decisions concerning the withdrawal or withholding of medical treatment, in cases of

incompetent patients, are required to be taken in accordance with the best interest principle. Both the best interests of the patients and medical and non-medical considerations should be given importance. The best interest should be that the treatment helps in recovery or improvement and not merely prolong biological existence without any prospect of meaningful recovery. The court in this case held that withdrawal of CANH from the applicant would be in his best interest.

It was the first case in which the Supreme Court applied passive euthanasia wherein the patient had not executed an AMD, and in such case, the guidelines established in common cause procedure were legally followed, confirming that the framework applies equally to incompetent patients without prior directives, with family consent and medical board certificate substituting for the patient's own directive.

There exists an urgent necessity to fill this vacuum through a comprehensive statutory framework. While the guidelines laid down in *Common Cause* (supra) serves the purpose, it was never intended to operate as a permanent substitute for legislation. There is a necessity to fill the vacuum through statutory legislation. One that provides definitional clarity, institutional accountability, bodily autonomy, and protection for the full spectrum of end-of-life situations that judicial guidelines alone cannot adequately answer.

While *Harish Rana (2026)* represents a constitutionally significant and humanely reasoned judgment, a critical examination reveals that the decision advances the law on certain fronts while leaving equally important questions insufficiently addressed. The lack of statutory comprehensive legislative framework exposes medical professionals to potential civil, criminal, and disciplinary consequences arising from the withdrawal of life-sustaining support despite judicial guidelines. Whereas, in the United Kingdom, the Mental Capacity Act,2005[10] grants medical professionals' legal protection if they follow the statutory process, which is lacking in India. Such uncertainty is likely to discourage medical professionals and undermine the effective implementation of passive euthanasia in practice.

A further structural vulnerability in the *Common Cause* (supra) framework, one that neither the 2023 modification nor Harish Rana has addressed, is the risk of fabrication and institutional misconduct. There is always a risk in our country that the procedure established may be

[10] Mental Capacity Act 2005, c. 9 (U.K).

misused by some unscrupulous persons who wish to inherit or are otherwise motivated by inheritance or financial interest in the patient's estate. Given documented instances of medical fraud and the financial stakes involved in inheritance disputes in our society today, and the rampant commercialization and corruption, we cannot rule out the possibility that unscrupulous persons with the help of some unscrupulous doctors may fabricate material to show that it is a terminal case with no chance of recovery. This necessitates a modification of the existing framework by appointing an independent body or a medical board drawn from outside the territorial jurisdiction of the concerned JMFC. It is suggested that either state government or the High Court be empowered to constitute an independent Medical Review Board comprising specialists drawn from outside the district or a different state. Such a Board, appointed through a centralised and transparent mechanism this may deter the fabrication of the document, and strengthen the procedure and lend greater credibility and legitimacy to the process of certifying a patient terminally ill with no possibility of recovery.

While Common Cause entrusted the JMFC with the appointment of the Medical Board and registration of Advance Medical Directives, this cannot be equated with the independent statutory review bodies. As established in Belgium and New Zealand, in Belgium, the Federal Control and Evaluation Committee independently reviews every case of euthanasia[11], serving as an accountable mechanism against misuse. Similarly, in New Zealand, the End-of-Life Choice Act 2019[12] established the SCENZ group, a dedicated registry of practitioners, to prevent coercion and fabrication. India has no such independent review body and thus accountability mechanism remains a critical gap that neither 2023 modifications nor Harish Rana has addressed.

CONCLUSION

Harish Rana v. Union of India, is the judgment that simultaneously advances passive euthanasia in India, it is progressive in outcome yet structurally vulnerable. In the case of *Harish Rana* [13](supra) Supreme Court stepped up and approved passive euthanasia by allowing the medical professionals to withdraw life-sustaining CANH so that the patient can die with dignity, preserving bodily integrity rather than prolonging suffering through artificial means. even without executing AMD and the decision was arrived at on the best interest of the patient. This

[11] Belgium Act on Euthanasia, 28 May 2002 (Belg.).
[12] End of Life Choice Act 2019, 2019 No. 67 (N.Z.).
[13] *Harish Rana* supra (n 1).

judgment was supported by the precedent set in the judgment of *Common Cause* (supra).

The right to die with dignity did not emerge from legislative foresight but was gradually apprehended and crystallised through judicial interpretation of Article 21. From P. Rathinam's tentative recognition of the right to die, to *Gian Kaur's* clarification that a dignified death falls within the ambit right to life, to *Common Cause*, which conclusively held that Article 21 encompasses the right to die with dignity and lays down procedural guidelines for withdrawal of life-sustaining treatment. Parliament has remained a silent spectator throughout this constitutional evolution.

Significantly, the procedural gaps left unaddressed in *Aruna Shanbaug* were partly remedied by common cause. yet even this correction was judicial, not legislative, and as Harish Rana demonstrates, guidelines crafted by courts can be departed from by courts, leaving the law in a state of perpetual uncertainty. What is therefore needed is not another landmark judgment, but a comprehensive statutory framework. Such a framework must codify the AMD process, standardise Medical Board composition, translating judicial aspiration into an enforceable legal right. Until then, the promise of passive euthanasia in India remains more aspirational than operational.