
**BEST INTEREST PRINCIPLE IN PASSIVE EUTHANASIA
JURISPRUDENCE (2026 LENS): COMPARATIVE ANALYSIS
OF THE SUPREME COURT’S 2026 REFINEMENTS TO
COMMON CAUSE GUIDELINES ON WITHDRAWING
ARTIFICIAL NUTRITION/HYDRATION, EXPLORING
DIGNITY, AUTONOMY, AND NON-VOLUNTARY CASES
THROUGH NATURAL LAW VS. POSITIVIST LENSES**

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ABSTRACT

The Supreme Court of India’s judgment in *Harish Rana v. Union of India* (2026 INSC 222, decided 11 March 2026) marks the first comprehensive application of the passive euthanasia framework laid down in *Common Cause v. Union of India* (2018). This article analyses the

Court’s 2026 refinements, particularly the classification of Clinically Assisted Nutrition and Hydration (CANH) as medical treatment, the elaboration of the “best interest” principle, procedural streamlining, and mandatory palliative care. Focusing on non-voluntary cases involving patients in persistent vegetative state (PVS), it examines how these refinements balance dignity and autonomy under Article 21. Through a comparative philosophical lens, the article argues that while the judgment employs positivist procedural tools for predictability and safeguards, its substantive core draws upon natural law principles of inherent human dignity and qualitative flourishing. The analysis highlights the need for parliamentary legislation to codify this evolving jurisprudence.

Keywords: Passive euthanasia, Best interest principle, CANH withdrawal, Article 21, Dignity, Autonomy, Natural law, Legal positivism, *Harish Rana* (2026).

Introduction

In *Harish Rana v. Union of India* (2026 INSC 222, decided 11 March 2026), the Supreme Court of India, in a bench comprising Justices J.B. Pardiwala and K.V. Viswanathan, authorised the withdrawal of life-sustaining treatment—including CANH administered via PEG tube—for a 32-year-old man who had remained in a persistent vegetative state for over thirteen years following a 2013 traumatic brain injury. This marked the first time the constitutional framework established in *Common Cause v. Union of India* (2018) 5 SCC 1 was applied “in full measure” to a concrete non-voluntary case.

The judgment resolves several practical ambiguities that had hindered implementation: whether CANH constitutes “medical treatment” (as opposed to basic care), the precise contours of the “best interest” test, procedural streamlining for overburdened healthcare settings, and the mandatory integration of palliative and end-of-life care. By doing so, *Harish Rana* transforms the “right to die with dignity” from a theoretical declaration into a workable constitutional reality under Article 21.

This article examines the 2026 refinements with a dual focus. First, it traces the doctrinal evolution from *Gian Kaur*, *Aruna Shanbaug*, and *Puttaswamy* to *Common Cause*. Second, it analyses the best interest principle, CANH classification, procedural streamlining, and palliative mandates. Finally, it offers a comparative philosophical lens—positivist and natural law—to illuminate how the judgment achieves a productive synthesis. The central thesis is that *Harish Rana* employs positivist methodology for rule-of-law clarity while grounding its substance in natural-law commitments to inherent human dignity and qualitative flourishing.

Doctrinal Foundations: Evolution under Article 21

The constitutional foundation for passive euthanasia rests on a progressive interpretation of Article 21.

In *Gian Kaur v. State of Punjab* (1996) 2 SCC 648, a Constitution Bench held that Article 21 guarantees the right to live with human dignity, which extends to a “dignified procedure of death” for the terminally ill or those in PVS. While rejecting a general “right to die,” the Court left open the possibility of passive euthanasia as a lawful omission rather than an active intervention.

Aruna Ramchandra Shanbaug v. Union of India (2011) 4 SCC 454 took the next step by recognising passive euthanasia in “rarest of rare” cases. The Court distinguished active euthanasia (positive act causing death, impermissible) from passive euthanasia (withholding or withdrawing treatment, permissible under strict safeguards, including High Court approval acting as *parens patriae*). Though the specific plea for Aruna was rejected, the judgment established procedural guidelines that influenced later developments.

Justice K.S. Puttaswamy v. Union of India (2017) 10 SCC 1 (nine-judge bench) enriched this framework by declaring the right to privacy as intrinsic to Article 21. Privacy encompasses decisional autonomy and bodily integrity, empowering competent individuals to refuse treatment and providing a doctrinal bridge for proxy decision-making in incompetent cases. These precedents culminated in the Constitution Bench decision in *Common Cause v. Union of India* (2018) 5 SCC 1, which legalised passive euthanasia, validated Advance Medical Directives (living wills), and laid down detailed procedural safeguards. The 2023 modifications attempted to address implementation difficulties, yet practical challenges persisted until Harish Rana applied the framework comprehensively.

Key 2026 Refinements in Harish Rana

A. CANH as Medical Treatment

The Court decisively held that Clinically Assisted Nutrition and Hydration (via nasogastric or PEG tubes) constitutes “medical treatment,” not mere basic sustenance or nursing care. It is technologically mediated, requires medical prescription, carries risks (infections, aspiration, electrolyte imbalance), and demands ongoing supervision and periodic review. This classification aligns CANH with other life-sustaining interventions such as ventilation, making its withdrawal a lawful omission within the passive euthanasia framework rather than impermissible “starvation.” The reasoning draws on international precedent, notably *Airedale NHS Trust v. Bland* [1993] AC 789.

In *Harish Rana*, continued CANH was found to prolong an artificial, undignified existence without therapeutic benefit, justifying its withdrawal.

B. Streamlining of Common Cause Procedures

The judgment addresses the cumbersome nature of earlier guidelines by:

Clarifying roles of primary (treating team) and secondary medical boards (nominated by the Chief Medical Officer, with expanded specialist pools).

Assigning a largely notificatory role to the Judicial Magistrate of First Class where boards reach unanimity.

Creating explicit pathways for home-care patients (admission to hospital or designation of a primary treating physician).

Allowing waiver of the standard 30-day reconsideration period in clear, unanimous cases. These refinements respond to India's healthcare realities while preserving safeguards against abuse.

C. Mandatory Palliative and End-of-Life Care

Withdrawal is never abandonment. Every decision must be accompanied by a "robust palliative and end-of-life care plan" prioritising comfort, pain relief, and dignity. In *Harish Rana*, the Court directed admission to AIIMS Delhi's palliative care unit, emphasising a humane shift from life-prolonging to comfort-focused care.

IV. The Best Interest Principle: Anatomy and Application

For incompetent (non-voluntary) patients lacking capacity and without an Advance Medical Directive, the "best interest" principle governs decisions.

The Court clarifies that the question is not whether it is in the patient's interest to die, but whether it is in their best interest that life be prolonged by the continuance of this particular medical treatment. This reframing places the onus on justifying continued artificial prolongation.

The test is holistic and multi-factorial:

Medical factors: Futility, burden versus benefit, irreversibility, prognosis.

Non-medical factors: Patient's known wishes, values, beliefs (strong substituted judgment element), dignity, quality of life in the widest sense, family/relational context.

In Harish Rana, unanimous medical board opinions on irreversibility, combined with family input on dignity, led to the conclusion that continued CANH was not in the patient's best interest.

The judgment surveys international approaches (USA Cruzan, UK Aintree balance-sheet, Italy Englaro, Australia, New Zealand, EU) before tailoring a flexible framework suited to Indian constitutional values, with dignity as the “unifying and omnipresent force” under Article 21.

V. Philosophical Lenses: Natural Law versus Positivism

Harish Rana exemplifies a productive dialectic between legal positivism and natural law theory.

From a positivist perspective (H.L.A. Hart, *The Concept of Law*), the refinements derive validity from social facts: constitutional text, stare decisis (*Gian Kaur to Common Cause*), and secondary rules of procedure. Streamlining (board roles, notificatory JMFC function, documentation) ensures predictability, anti-arbitrariness, and separation of powers. CANH classification and best-interest balancing become workable legal constructs, not moral absolutes. This approach makes the framework justiciable and practical in a diverse, resource-constrained society.

From a natural law perspective (Thomas Aquinas, *Summa Theologica*; John Finnis, *Natural Law and Natural Rights*), law must align with reason and basic goods of human flourishing, including life, practical reasonableness, and sociability. Human dignity is inherent, not merely posited. Prolonged futile treatment in PVS offends the qualitative dimension of life, reducing a person to “mere biological existence.” The holistic best-interest test—incorporating substituted judgment and dignity—reflects practical reasonableness and the principles of beneficence and non-maleficence. Withdrawal of CANH as an omission (allowing natural death) differs morally from intentional killing, while palliative mandates uphold non-maleficence.

The judgment achieves synthesis: positivist method provides procedural rigour and safeguards; natural-law substance infuses moral depth, particularly in non-voluntary cases where direct autonomy is impossible and dignity serves as a standalone constitutional anchor.

This enriches Article 21 without collapsing into unchecked subjectivity or rigid vitalism.

VI. Conclusion

Harish Rana (2026) represents a mature step in India's passive euthanasia jurisprudence. By classifying CANH as medical treatment, elaborating a patient-centric best interest principle, streamlining procedures, and mandating palliative care, the Court has translated constitutional dignity into practical reality. Its philosophical synthesis—positivist form serving natural-law substance—offers a balanced model that respects individual personhood while maintaining systemic safeguards.

As India confronts an ageing population and advancing medical technology, this 2026 lens underscores that the right to life under Article 21 includes the right to a dignified death. The onus now lies on the legislature to build upon this judicial foundation with humane, clear, and accessible law.

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