PASSIVE EUTHANASIA: OPERATIONALISING THE RIGHT TO DIE WITH DIGNITY [CASE COMMENT ON HARISH RANA V. UNION OF INDIA (2026)]

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"Death is not always the enemy of life; sometimes, it is the final refuge of dignity."

ABSTRACT

The case of *Harish Rana v Union of India (2026)* marks a paradigm shift in the euthanasia laws in our country. The case, authored by a two-judge bench, analyses the tussle between the sanctity of life and constitutional morality. Through this case, the application of the guidelines in the judgment of *Common Cause v Union of India (2018)* can be seen for the first time in our country by allowing passive euthanasia and ensuring the right to die with dignity under Article 21. It provides a comprehensive interpretation and streamlining of the procedure for withdrawing life-sustaining medical treatment, especially Clinically Assisted Nutrition and Hydration (CANH).

Keywords: Article 21, Right to die with dignity, passive euthanasia, CANH, best interest principle

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BENCH: Justice J.B. Pardiwala, Justice K.V. Viswanathan

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INTRODUCTION

The first thing that needs to be understood is what 'euthanasia' is. It is derived from the conjunction of two Greek terms- 'Eu' meaning good, and 'Thanos' meaning death, euthanasia means 'good death'. It is also known as mercy killing or physician-assisted death.[1] The distinction between 'active euthanasia' and 'passive euthanasia' is that active euthanasia is a positive act or external agency of harm that is introduced to hasten the death of the person, which otherwise would not have happened naturally, which makes it immoral and passive euthanasia is the withdrawal or withholding of life-supporting treatments of the person and let the nature take its own course.[2] Only passive euthanasia with proper safeguards is allowed, and active euthanasia is strictly prohibited and will entail criminal liability.

FACTS IN BRIEF

The petitioner, Mr Harish Rana, aged 20 at the time of the incident (now 32), was studying B.Tech at Punjab University while living in a paying guest facility. On August 20, 2013, he fell from the fourth floor of his accommodation, resulting in diffuse axonal injury. He received treatment at PGI Chandigarh for his serious condition, but showed no signs of recovery even upon discharge. Following this event, he continued receiving care at Jai Prakash Narayan Trauma Centre at AIIMS Delhi for head injuries, seizures, pneumonia, bedsores, among other issues. Since then, he has been reliant on tracheostomy and urinary catheterisation while being fed via a PEG tube due to CANH. His neurological state showed no improvement; he remained completely bedridden and unresponsive for 13 years—leading to painful bedsores— and medical assessments classified him as being in a Persistent Vegetative State (PVS) with complete physical impairment. The primary and subsequent secondary medical boards

[1] "*Harish Rana dies after spending 13 years in coma: What are India's euthanasia laws*?" on Firstpost
[2] Harish Rana v Union of India (2026) INSC 222

evaluated him according to Common Cause's guidelines; both concluded that his condition was irreversible with negligible chances for recovery. The applicant's family petitioned the Hon'ble Court to put an end to his suffering.

ISSUES

1. Whether the CANH can be categorised as 'medical treatment'?

2. What does "best interest of the patient" entail regarding withdrawing/ withholding medical treatment?

3. Whether prolonging life through continued treatment would be in the best interest of the applicant?

4. What steps must be undertaken if a decision to withdraw or withhold medical treatment is arrived at?[3]

ANALYSIS AND OBSERVATIONS BY THE APEX COURT

The Hon'ble Supreme Court, while answering the first issue in the affirmative, observed that CANH cannot be regarded as a means of primary care, but a technologically mediated medical intervention that must be subject to the same ethical and legal principles governing other life-sustaining treatments. The medical intervention is prescribed, supervised, and periodically reviewed by trained professionals in accordance with medical standards; excluding them from the purview of medical treatment would deprive them of the ability to assess the therapeutic value. The court also highlighted the difference between spoon- feeding and CANH administered through a PEG tube to explain that it is not basic care but a medical intervention employed to prolong the life of the applicant, but does not contribute to improving his condition.

To determine whether medical treatment is to be withdrawn or withheld, the doctors and the courts must keep in mind the principle of "best interest of the patient" as per the Common Cause 2018(supra). While referring to the judgment of Airedale, Deepak Misra, C.J., discussed that life-sustaining treatments can be withdrawn if the patient consents to it and in case of

[3] Ibid

incompetent patients, if it is in the best interest to do so. The Hon'ble Court also visited the jurisprudence of various countries as to what would constitute the "best interest of the patient" and referred to the reports of the 196th[4] and 241st [5]Law Commission on the medical treatment of terminally ill patients. The best interest principle must not only include the medical interest of the patient but also certain non-medical considerations, such as ethical, social, moral, emotional, and other welfare considerations. Factors such as the futility of treatment, no hope of recovery or cure, and the indignity of the patient, all of which form a part of medical considerations. If the patient is incompetent to make his choices, his wishes expressed in advance, in the form of a living will, or the wishes of the surrogates acting on his behalf under the substituted judgment standard, are to be respected. In such a case, the surrogate is expected to represent what the patient may have decided had he/she been competent.[6]

The medical considerations in the present case admit of no ambiguity. The treatment being administered to the applicant has become prolonged, futile, and offers no hope of recovery. The applicant has remained in a PVS for over 13 years, with irreversible and non-progressive brain damage, and the continuation of CANH serves only to sustain biological existence without any prospect of cognitive recovery or improvement in condition. The conclusion reached by the medical boards in the present case is that the withdrawal of CANH is in the applicant's best interests and is, and both medically sound and consistent with a patient-centric assessment of dignity, values, and welfare.[7]

In case the decision of withholding/ withdrawing the life-supporting treatment is arrived at, the duty of the medical professionals does not end there; it just transcends into another dimension known as EOL (End of Life) Care or Palliative care. The resultant effect should not be the abandonment of the patient; the focus should now shift towards pain and symptom management. Discontinuation of a futile treatment would not be an 'illegal omission' but fulfilment of the doctor's duty. A continuous assessment of the daily support plan should be done and reviewed by the team of doctors daily. In the present case, a step-by-step withdrawal or withholding would ensure the applicant's best interest while getting proper palliative care to alleviate pain, further ensuring the applicant's dignity.

[4] Law Comm'n of India, 196th Report: Medical Treatment to Terminally Ill Patients (Protection of patients and medical practitioners) (2006)
[5] Law Comm'n of India, 241st Report: Passive Euthanasia: A Relook (2012)
[6] Harish Rana v Union of India (2026) INSC 222
[7] Ibid

COMMENTARY

This case is a sheer example where constitutional morality prevails over the sanctity of life; that is, the right to die with dignity overwhelms the state's interests to safeguard the life of its citizens. There is a catena of judgments by the Hon'ble court that led to the evolution of law regarding passive euthanasia. In the P. Rathinam case[8], for the first time, autonomy and self-determination were recognised by the Court, and it was held that the right to die will come under the purview of the right to life under Article 21. It was subsequently overruled in Gian Kaur, where the court held that the right to life does not include the right to die, though it introduced a significant idea that the right to die with dignity may be valid in terminal illness.[9] which paved the foundation of passive euthanasia. The first legal recognition of passive euthanasia was done in the landmark case of Aruna Shanbaug, where it allowed the withdrawal of life support, subject to the approval of the High Court and the medical board[10]. Then came the precedent of Common Cause, which recognised the right to die with dignity as a fundamental right and discussed the validity of living wills/ advance directives[11]. It simplified the complex procedure of passive euthanasia and laid down the guidelines to regulate it. The constitution of the primary medical board, as well as the secondary medical board to analyse the condition of the patient, was among the guidelines of common cause. In case of dissatisfaction with the opinion of the board, the guardians can also approach the High Court by way of a writ under Article 226. Harish Rana is the first case of implementation of the guidelines laid down in Common Cause.

The case has wide social ramifications. It strengthens the idea of self- determination and autonomy over one's body and life, which reassures dignity over vegetative life. It also includes those who are incompetent to give consent, and in their case, the best interest of the patient will be considered, which would be patient-driven and not parent-driven. It does not exclude the patients who are being cared for at home in their vegetative state, as the guidelines equally apply to them. It allows the medical professionals to withdraw life-sustaining treatment under proper safeguards, which provides legality to the ethical decision-making by the medical professionals. There is one concern that economic hardships faced by a family during long-term life support may push them to pursue this. The vulnerable group, such as the elderly and

[8] P. Rathinam v Union of India (1994) 3 SCC 394
[9] Gian Kaur v State of Punjab (1996) 2SCC 648
[10] Aruna Shanbaug v Union of India (2011) 4 SCC 454
[11] Common Cause v Union of India (2018) 5 SCC 1

disabled, might be coerced or influenced for this, putting them at risk, but again, the guidelines suggest that the best interest of the patient will be seen by the deciding authority, making the chances of misuse negligible. It also intensifies the debates between the sanctity of life and the quality of life, as certain religious and social belief systems oppose putting an end to life in any given scenario.

CONCLUSION

The judgment affirms the right to die with dignity and reaffirms autonomy and the right to privacy as held in Puttuswamy. As per Article 21, the life of a person can only be deprived by a procedure established by law, which calls for a legislative action. The need for a statutory framework on this would fill the gaps and provide legal backing. The core issues in the case were whether CANH would come under the purview of medical treatment and the contours of the best interest principle when the patient is incompetent to consent. The guardians/ caretakers would decide as if they were in the shoes of the patient and what the patient would have wished had he been competent to decide (substituted judgment standard). Medical and non-medical factors should be ascertained while deciding the best interest. A balance sheet, comparing the pros and cons of the continued treatment, should be prepared by the decision makers. The withdrawal/ withholding of life-sustaining treatments should not result in abandonment of the patient. Rather, the doctor would switch to palliative or EOL care to minimise suffering and uphold dignity so that the patients can meet a humane end.