ARUNA SHANBAUG LIVED, SO HARISH RANA COULD DIE: A NOTE ON HARISH RANA V. UNION OF INDIA[1]

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I. Introduction

The story of passive euthanasia in India has been running through three significant cases across fifteen years. I first read about Aruna Shanbaug back in 2022, when I was preparing for my law entrance exams, and it stuck with me. In Aruna Shanbaug v. Union of India[2], the Supreme Court first recognised that passive euthanasia could be constitutionally permissible, although it did not grant relief to Shanbaug herself, a nurse who had been in a persistent vegetative state for almost forty-two years due to a brutal assault upon her. Shanbaug died of pneumonia in 2015. The judgment that bore her name, however, outlived her; the case closed, but what it stood for did not. The judgment established the concept that Article 21 which provides right to life, also encompasses the right to die with dignity, and that withdrawing life-sustaining treatment from a patient in a permanent vegetative state is not the same as causing death. In 2018, Common Cause v. Union of India[3], built the procedural architecture on that foundation, recognising Advance Medical Directives, laying down guidelines for medical boards, and affirming that the right to die with dignity extended beyond cases of terminal illness to those in a persistent vegetative state. Then, on March 11, 2026, the Supreme Court applied that architecture for the first time in Harish Rana v. Union of India, permitting the withdrawal of Clinically Assisted Nutrition and Hydration (CANH) from a 32-year-old man who had been in a Permanent Vegetative State for over thirteen years following a catastrophic brain injury suffered due to falling from his hostel's window. To paint a clearer picture, I would like to differentiate between Active and Passive Euthanasia, as to what I understood after reading the Harish Rana Judgment.

II. Active versus Passive Euthanasia, what is the Distinction

Justices Pardiwala and *Viswanathan* finally applied the framework in a live case. Harish was

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[1] (2026 INSC 222)

[2] (2011) 4 SCC 454

[3] (2018) 5 SCC 1

twenty years old when he fell from a building in 2013 and suffered a severe brain injury. Permanent vegetative state for thirteen years. Quadriplegic, 100 percent disability, no awareness. Harish was kept alive only with a PEG tube delivering CANH. His parents asked the courts to let him go. Delhi High Court said no in 2024. The Supreme Court allowed it. The judgment is long, clinical, and honest about the gaps. It forced me to re-think about how law catches up with life and death. According to the judgment, passive euthanasia means withdrawal or withholding of life-sustaining medical treatment. It is basically an omission. You stop the artificial support so the underlying condition can take its natural course. Death is attributed to the injury, not to any new act.

To the High Court's concern that withdrawal would amount to starvation, Supreme Court addressed this concern directly: removing the tube does not cause death, it just simply stops preventing it.

On the other hand, Active euthanasia is different. It involves a positive, deliberate act, for example giving a lethal injection which is intended to cause death right away. So basically, the medicine injected into the person, causes their death, that is active euthanasia. It, however, remains completely illegal in India. The Harish Rana Judgment keeps the line clear: passive euthanasia is removal of something that was artificially delaying the dying process; whereas active introduces a new external cause which results in death. At first glance this seems straightforward. And on these extreme facts it works cleanly. But honestly, I am not entirely convinced the line will always stay this sharp in future cases.

III. The CANH Question: Whether it is a Medical Treatment or just Basic Care?

This classification of CANH actually determined whether the Common Cause framework applied at all or not. If CANH is basic care, the passive euthanasia procedure simply does not get triggered, regardless of how severe or irreversible the patient's condition is. The family would have had no legal route.

Then, the Delhi High Court in 2024 said it was not medical treatment. Their reasoning was along the lines of: Rana was not on a ventilator. Removing the PEG tube would not let his underlying injury take its natural course. He would die without nutrition and water. That would look more like starvation than passive euthanasia. I honestly did not completely understand why the High Court did not treat CANH as a medical treatment, when you were given something as basic as water and food through PEG Tubes.

But I believe the Supreme Court got it right. They went to the clinical reality of what CANH actually involves. The PEG tube is surgically inserted. The nutritional formula is individually calculated. There is constant monitoring for metabolic instability, gastrointestinal tolerance, and infection at the insertion site. Even when administered at home, the process must run on strict medical protocols prescribed by a clinician. Dislodging a PEG tube requires immediate medical supervision because reinsertion of the tube carries a real risk of peritonitis (An inflammation in the tissue that lines your belly). This is not regarded as feeding someone. It is a continuous, supervised, technology-dependent intervention in the body's processes. The Court held, that it is medical treatment. Once that was established, the rest of the Common Cause procedure followed.

IV. Best Interest and Substituted Judgment: A Relatively Harder Part

With CANH decided as medical treatment, the Court still had to decide whether withdrawing it was actually in Harish's best interest. This issue is harder, and honestly the one I keep coming back to. Harish Rana had left no Advance Medical Directive, which meant that the Court was required to make a non-voluntary decision on Rana's behalf, i.e. making an end-of-life decision for a person who had no opportunity to consent. The mechanism through which it did so is known as the "best interest of the patient" principle, which Harish Rana's judgment develops considerably beyond what Common Cause had articulated.

At paragraph 310, the Court framed the central issue with precision: the question is not whether it is in the patient's best interest to die, but whether it is in his best interest that life should be prolonged by the continuation of the treatment in question. This reframing, in my opinion, was important. That small shift keeps the focus on the treatment, its effects and the intervention rather than on judging the value of a disabled life.

The Court then holds, at paragraph 311, that the best interest principle cannot be "a narrow, rigid, formulaic and straight-jacketed single test." It must incorporate both medical and non-medical considerations. The medical considerations include prognosis, futility of continued treatment, and whether treatment merely prolongs suffering without any realistic therapeutic benefit. The non-medical considerations include dignity, the patient's reconstructed wishes and values, and the views of family members who have acted as caregivers for long.

Importantly, the Court at paragraphs 314 and 315 incorporates a version of the substituted judgment standard within the best interest framework. Decision-makers must try to stand in Harish's shoes and ask what his wishes and attitude to treatment would have been. They must not substitute their own feelings, beliefs, or values. Although, the substituted judgment standard does not operate autonomously or in an overriding way: the ultimate governing question remains what course of action serves the best interest of the patient, whose condition has remained irreversible for years.

Still, the framework leaves me uneasy. The Court does not establish a hierarchy of evidentiary sources for reconstructing a patient's wishes. It does not indicate how much weight should be given to a patient's prior statements, if any, versus the testimony of family members. It does not require independent social or psychological assessment of caregivers whose grief, financial constraint, and years of exhausting home care may, entirely understandably, colour their account of what the patient would have wanted. Though, in Rana's case, everything aligned. The medical boards, doctors, and parents were unanimous after thirteen years of devoted care. But, in reality, the framework as written will govern future cases, where, to be fair, everything will not align such smoothly. In clean cases like this one, it works. In messier ones I worry lower courts will be left guessing. Where the family's dynamics would be opaque, where there would be disagreement among relatives, or where the patient's prior values and preferences would never be clearly expressed. Good faith is being asked to carry a lot of weight here, and that worries me a little.

V. The Legislative Vacuum: What the Court Could Not Fix

This is the part that has left the strongest aftertaste on me. It is uncomfortable, yet true. The Court openly admits something difficult. Without a real statute or legislation, end-of-life decisions are shaped by things that have nothing to do with medicine or dignity. They are decided in homes where money is running out, where families have been caregiving for a decade, where insurance does not exist. What looks like a compassionate choice can sometimes just be a family that has reached its limit. The Court mentions this risk and that must’ve taken courage to write.

But being fairly honest, naming the problem is not the same as fixing it. The guidelines the Court keeps issuing have always meant to be temporary bridges; the court clears this in paragraph 290. Parliament must step in and legislate. Here we are in 2026, where the Court is again spelling out detailed rules for medical boards, magistrates, High Courts, AIIMS, and the Union Government. The Law Commission addressed end-of-life care in its 196th Report in 2006. The Supreme Court decided Aruna Shanbaug in 2011, then, Common Cause in 2018. Draft guidelines came in 2024 and went nowhere. Judges keep doing the legislature's homework because they have to step in "out of constitutional necessity rather than institutional choice."

A legislative framework, whenever it arrives, will eventually need to address questions that judicial guidelines are structurally unable to resolve permanently: the position of patients with no family support; the duties, rather the obligations of private hospitals; the role of independent patient advocates, and the evidentiary standards for reconstructing patient autonomy in the absence of a prior AMD.

I come from a well-to-do family in Sonipat. During the second wave of CoVID-19, when my maternal uncle had contracted the virus, I watched what happens when the state offers almost nothing. I saw the weight, emotional and financial, falling entirely on the family and that too during a pandemic. What I remember the most is not just what happened to him, but everything around it. The running around, the phone calls, the helplessness. It wasn't really about "end-of-life choices" or dignity in the way we discuss it in law. It was much simpler, and harsher than that. The system just wasn't there when it needed to be. That experience is why this part of the judgment reads differently to me. It is not the same situation as Rana's. But it is the same underlying truth: when the state withdraws, families pay the price. When the state fails to provide basic healthcare infrastructure, "choice" and "dignity" start to feel hollow. For someone who believes the Constitution should protect the most vulnerable first, I actually worry. The right to die with dignity cannot truly exist if the system quietly forces poor families into impossible choices.

No court can fix that from the very bench it sits on. It needs a law. It needs the state to actually show up. The judgment asks for all of this. Whether anyone listens is another question entirely.

VI. Conclusion

Harish Rana v. Union of India is, on its facts, a correct and humane judgment. The CANH classification closes a critical gap in the Common Cause judgment. The expanded best interest standard, when read together with the Court's careful incorporation of substituted judgment, offers a richer framework for non-voluntary decisions than Indian law previously had. And the final paragraphs of the judgment, where Justice Pardiwala addresses Rana's family directly and describes the decision as sitting "in a space between love, loss, medicine and mercy," reflect a judicial sensibility that takes seriously the weight of what is being permitted. That human note is unusual, and it matters a lot.

The judgment's limitations are of a kind that cannot be resolved within a single case. The best interest standard needs clearer evidentiary structure, particularly for cases where family consensus is absent or is compromised. The safeguards for non-voluntary decisions need independent institutional architecture, not just a requirement of good faith from the people involved. And the broader framework needs Parliament, not because courts lack the authority to develop constitutional law in this area, but because law governing the end of human life requires democratic legitimacy and the capacity for iterative legislative revision that courts cannot provide.

Aruna Shanbaug lived so the law could evolve, so Harish could finally be allowed to leave with dignity. Now the question is whether we will build a system that actually works for every family, rich or poor. As a final-year student who thinks law must centre the vulnerable, I hope this judgment finally puts Parliament into acting. The issue has always been sensitive. It has always been uncertain. That is exactly why we needed legislation years ago. This is why we still do.

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