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Evolving Jurisprudence on the Right to Die with Dignity: Case Analysis of Harish Rana v. Union of India

ABSTRACT

The constitutional argument over the 'Right to Die with Dignity' continues to be one of India's most intricate intersections of law, medical, and ethics. The Apex Court's decision in Harish Rana v. Union of India 2026 case is an important advance in the evolving jurisprudence on passive euthanasia and end-of-life decision-making under Article 21 of the Indian Constitution. This case note critically examines the judgment's legal rationale and constitutional ramifications, focusing on the recognition of dignity, autonomy, and integrity of body as key components of the 'Right to Life'. The case involved a patient who had a catastrophic brain injury and spent more than thirteen years in a lifelong vegetative condition. The petitioner raised significant issues about the nature of artificial life-sustaining therapy and the extent of passive euthanasia in India by requesting judicial authority to stop clinically assisted nourishment and hydration. The Supreme Court reiterated that the right to life under Article 21 includes the right to die with dignity in situations where continued medical intervention merely prolongs an irreversible state of unconsciousness, building on earlier constitutional precedents interpreted in earlier cases of Common Cause and Aruna Shanbaug cases. The Court also cited comparative foreign jurisprudence from Britain, the United States, and Canada, including decisions such as Airedale NHS Trust v. Bland, Cruzan case against Missouri Department of Health, Vacco case, and Rodriguez v. Attorney General of Canada. These cases were used to clarify the difference between active euthanasia and cessation of medical treatment. The article contends that the decision promotes the dignity-based interpretation of Article 21, While underlining the crucial need for comprehensive regulations governing assisted suicide and end-of-life care in India. The ruling held that clinically assisted nutrition and hydration are medical treatments that can be withdrawn once they do not meet the patient's primary needs, subject to safeguards such as independent medical board review, while also advocating for comprehensive end-of-life care legislation

in India. This article examines the Court's reasoning using constitutional principles, medical jurisprudence, and comparative international case law, arguing that the decision strengthens the dignity-centered interpretation of Article 21, while also highlighting India's continued lack of a coherent statutory framework governing euthanasia.

KEYWORDS

Euthanasia, Article 21, Human Rights, Right to Die with Dignity, Medical Jurisprudence.

INTRODUCTION

Constitutional, ethical, and medical scholars have long debated whether a person has the right to pass away with dignity. The Supreme Court of India has gradually evolved its jurisprudence on euthanasia through landmark decisions in the case of Aruna Shanbaug (2011)[1] and Common Cause (2018) vs Union of India[2]. These verdicts acknowledged passive euthanasia and the legality of advance medical directives within the context of 'Article 21 of the Indian Constitution,' which provides the right to life and personal liberty.

The trial of Harish Rana v. Union of India (2026) was resolved by a Division Bench of two Supreme Court judges[3]. The Apex Courts two-judge panel led by Justices J. B. Pardiwala and K.V.Vishwanathan addressed complicated ethical and constitutional issues. The Supreme Court recognized human dignity's important significance in interpreting the right to life under Article 21. In its decision, the bench began by reflecting on the complicated issues that courts face in end-of-life cases. It quoted Henry Ward, an American preacher. Beecher: "God does not question a man's acceptance of life. That is not an option. You must accept it. The only question is how". The jury also cited Shakespeare's well-known "to be or not to be" dilemma, stating that courts at times had to make similarly difficult decisions when asked to determine end of life.

The case of 'Harish Rana v. Union of India (2026)' is an important development in this emerging jurisprudence. The case featured a young man who had been in a 'permanent vegetative state' (PVS)

[1] Aruna Shanbag v. UOI & Others (2011) [W.P.No 115 of 2009], decided on March 7, 2011

[2] Comon Cause (A Regd. Society) vs. UOI (2018) AIR 2018 SC 1665, in W.P (Civil) No. 215 of 2005.

[3] Harish Rana v. UOI & Ors., 2026 INSC 222; M.A No. 2238 of 2025 in SLP (Civil) No. 18225 of 2024.

for more than thirteen years due to a serious brain injury. His parents petitioned the Supreme Court for permission to remove life-sustaining medical treatment, including 'Clinically Assisted Nutrition and Hydration' (CANH) delivered via a feeding tube.

The case brought up difficult legal and moral issues pertaining to the definition of medical treatment, the function of caregivers, the use of the "best interests" principle, and the procedural application of rules for passive euthanasia set forth in previous constitutional rulings. These ruling highlights the need for the legal position of "Artificial hydration and food as medical care" is clarified by comprehensive legislation regulating end-of-life decision-making in India, which also outlines the procedural safeguards needed for withdrawing life-sustaining care.

FACTS OF THE CASE

Harish Rana, a young engineering student, was involved in a catastrophic accident in 2013 when he fell from the fourth storey of his housing. The fall resulted in serious traumatic brain injury, including 'diffuse axonal injury', which rendered him permanently vegetative. Following the accident, he received treatment at a local hospital before being transported to the Postgraduate Institute of Medical Education and Research (PGI) in Chandigarh. Despite considerable medical therapy, his neurological state did not improve. Over the years, he was entirely reliant on life-support technologies such as tracheostomy for breathing, eating through a Percutaneous Endoscopic Gastrostomy (PEG) tube, urine catheterization, and constant medical supervision. Medical evaluations indicated that he had 100% permanent impairment and total sensorimotor dysfunction [4].

For over a decade, his parents provided extensive home care. However, the family eventually realized that the continuing medical therapy had no therapeutic value and only prolonged his agony. The parents then petitioned the Delhi High Court for an order to discontinue artificial feeding and hydration. The High Court dismissed the case, noting that the patient was not being kept alive mechanically and hence judicial action was unnecessary. The family filed a Special Leave Petition with the Indian Supreme Court (SC) after being disappointed by this ruling. The Court ordered the establishment of a Primary and a Secondary Medical Board at AIIMS during the proceedings. Both boards attested to the patient's irreparable brain injury and the impossibility of a medical recovery. To determine whether extending life-sustaining treatment was in the "optimum benefit

[4] Supreme Court Judgement. Harish Rana v. Union of India 2026 INSC 222

of the recipient," the Supreme Court was consulted [5].

JUDGMENT OF THE SUPREME COURT

The Appellate Court discussed several significant legal concerns pertaining to Euthanasia by passive means and end-of-life decision-making in the case of Harish Rana. The main questions were whether CANH given via a feeding tube is considered medical therapy and if stopping it would be considered passive euthanasia. In evaluating whether life-sustaining treatment should continue when recovery is medically unlikely, the Court also looked at the use of the in the good interests of the person receiving treatment criterion. Another crucial issue was whether patients getting long-term home-based care as opposed to hospital treatment should be subject to the procedural protections outlined in Common Cause case in 2018, including the need for medical boards.

The Court also considered whether the patient's best interests were served by continuing to administer CANH in this instance. Lastly, the Court considered a more general institutional question: does India need a comprehensive legislative framework that governs end-of-life medical treatment and passive euthanasia instead of depending only on judicial guidelines? The Supreme Court issued a thorough ruling that addressed both pragmatic medical issues and fundamental constitutional concepts. The Court reiterated that the "Right to Live with Dignity" under Twenty first(21st) Article encompasses the "Right to Die with Dignity," especially where medical intervention just prolongs an irreparable condition of suffering. The Court clarified that CANH delivered via medical devices is considered medical treatment rather than basic care. As a result, such treatment may be legally withdrawn when it is medically ineffective and detrimental to the best interests of the sufferer.

The Court also reiterated the differences between both forms of euthanasia. Active euthanasia is still prohibited in India and entails a positive act intended to induce death. The removal or withholding of medical treatment is known as passive euthanasia, and it is permitted by The 21st article of the Constitution. The Court concluded that continued therapy would simply prolong a condition of irreversible unconsciousness and serve no therapeutic purpose after considering the medical boards' reports and the patient's family's opinions. Accordingly, the Court permitted the withdrawal of life-sustaining treatment, subject to

[5] High Court of Delhi order dated 02.07.2024 passed in Writ Petition (C) No. 4927 of 2024.

strict procedural safeguards and provision of palliative care [6].

REASONING AND LEGAL ANALYSIS

The decision in *Harish Rana v. Union of India* represents an important development in the constitutional jurisprudence of India concerning end-of-life care and passive euthanasia. The Court's reasoning is rooted in constitutional principles, medical ethics, and comparative jurisprudence. The judgment builds upon earlier landmark rulings of *Aruna Shanbaug* and *Common Cause* cases, while clarifying unresolved doctrinal questions about discontinuing life-sustaining therapy.

The constitutional foundation of the liberty to die with honor, the distinction between the two types of euthanasia, the acceptance of artificial water and food as medical care, the application of the " greatest interests of the patient" principle, and the necessity for a cogent legislative framework governing end-of-life decision-making are the five primary aspects which offer a broad understanding of the Court's analysis..

The Supreme Court's reasoning is firmly grounded in the constitutional interpretation of Article 21, which protects individual liberty and the right to life. The Court has given the provisions of Article 21 an expansive interpretation throughout time, transforming it from a narrow protection against state deprivation of life into a broad guarantee of human dignity and autonomy. In *Common Cause v. Union of India (2018)*, The Constitution Bench ruled that where medical care just prolongs pain or results in an irreversible condition of unconsciousness, the right to live includes the choice to pass away with honor. The Court recognised that forcing a patient to undergo futile medical treatment may violate the dignity component of Article 21.

This constitutional concept is strengthened by the ruling in Harish Rana. An individual's freedom to live life cannot be constrained to their biological existence, the Court stated. Article 21 defines human life as one that is characterized by autonomy, dignity, and meaningful consciousness. The Court stressed that if a patient is in a lifelong vegetative condition with little hope of recovery, it could not be in their best interests to continue artificial life-sustaining therapy. Instead, it can exacerbate pain and strain family members' finances and emotions. Justice Viswanathan highlighted the "limitless diversity of the individual state" in a different ruling. He feels it would be 'Irrational' to ignore the harsh reality of the family's 12-year vigil, even though

[6] Sheikh, A. (2026, March 12). How the SC allowed passive euthanasia for Harish Rana. The Indian Express.

the law offers a framework.. According to a Sanskrit subhashita (prose), "*Chita dahati Nirjivam Chinta dahati Jivanam*" which means "psychological stress" "burns the living one," as it is oftentimes more damaging than burial fire."[7]. Therefore, courts must determine whether continuing medical care serves the patient's welfare to uphold the constitutional duty to dignity. This reasoning reflects a shift in constitutional thinking from a '*purely life-preservatory approach'* in medical decision-making.

A central issue before the Court was the distinction between the both forms of euthanasia. Indian law historically prohibits euthanasia under criminal law provisions relating to homicide and abetment of suicide. However, judicial decisions have gradually recognised a limited form of passive euthanasia under strict conditions.

The Court reaffirmed that 'Active Euthanasia' remains illegal in India. Active dying is the intentional use of a terminal injection or poison to end a person's life. Criminal law applies to such acts since they directly result in death. In contrast, assisted suicide involves discontinuing treatments that artificially extend life. In such cases, death occurs due to the underlying medical condition rather than any positive act by the physician.

The Court clarified that the major difference between these two types of euthanasia should not be understood merely as a difference between acts and omissions. The physical act of withdrawing life-support equipment, such as removing a feeding tube or switching off a ventilator, may technically involve a positive action. However, the legal distinction lies in the intention and causation of death. In passive euthanasia, the physician's intention is not to cause death but to discontinue futile medical intervention. The patient ultimately dies due to the underlying illness. This distinction is crucial because it protects physicians from criminal liability when they withdraw medically futile treatment in accordance with legal guidelines. The Court's reasoning in this regard aligns with jurisprudence from several jurisdictions, including the Britain and the America, where courts have consistently recognised the legality of withdrawing life-sustaining treatment under certain conditions.

One of the most significant contributions of the judgment is its clarification that CANH constitutes medical treatment rather than basic care. Artificial nutrition and hydration are typically administered through medical devices such as nasogastric tubes

[7] https://theprint.in/judiciary/worry-more-devastating-than-funeral-fire-scs-poignant-order-in-harish-rana-passive-euthanasia-case/2876419/.

or percutaneous endoscopic gastrostomy (PEG) tubes[8]. While these methods provide essential sustenance, they require medical intervention and continuous supervision. The Court held that because these procedures involve invasive medical devices and clinical monitoring, they cannot be equated with ordinary feeding or caregiving. Instead, they constitute a form of medical treatment designed to sustain biological life. This distinction has important legal implications. If artificial nutrition and hydration are classified as medical treatment, they may be withdrawn when they no longer serve the best needs of the patient.

The Court drew support for this position from international precedents, particularly the decision of the House of Lords in the case of *Airedale NHS Trust case of 1993* in United Kingdom (UK), where artificial feeding was recognised as medical treatment that could be lawfully discontinued in cases of permanent vegetative state[9]. By adopting this reasoning, the Supreme Court removed an important ambiguity in Indian law and made it clear that tubes for nutrition are categorized as lifesaving medical treatments.

Another crucial aspect of the Court's reasoning is the adoption and application of the 'Best Interests Principle**'**[10]. This principle is widely used in medical law to determine what course of action most benefits a suffering who is incompetent of making decisions. In situations where a patient cannot express consent, courts must consider several factors, including medical prognosis, likelihood of recovery, pain and suffering, dignity and quality of life and wishes of family members and caregivers

The Court emphasized in the Harish Rana 2026 case that the main consideration is "not whether it is in the patient's interest to die," but instead how it is in the patient's benefit to carry on receiving therapy that has no therapeutic effect. Medical evidence presented before the Court indicated that the patient had remained in a permanent vegetative state for more than thirteen years with no possibility of recovery. Two independent medical boards concluded that continued treatment would not improve his condition.

The Court also considered the views of the patient's parents, who had cared for him for more than a decade. They expressed the belief that the continuation of treatment served no meaningful purpose and merely prolonged his suffering. Taking these factors into account, the Court of Appeal found that it was not in the

[8] https://www.verdictum.in/amp/court-updates/supreme-court/2026-insc-222-harish-rana-v-union-of-india-1609683

[9] Airedale NHS Trust v Bland, England & Wales, The Master of the Rolls,Lord justice butler-sloss, lord justice Hoffmann, [1992] EWCA Civ J1209-2.

[10] Harish Rana v. Union of India 2026 INSC 222

"greater good of the patient" to carry on life-sustaining treatment.

Aspect	Aruna Shanbaug (2011)	Common Cause (2018)	Harish Rana Case
Legal status of euthanasia	Passive euthanasia allowed	Right to die with dignity recognized	Reaffirmed earlier law
Living will	Not recognized	Recognized	Continued
Approval mechanism	High Court approval	Medical boards + magistrate	Tested practical application
Scope	PVS patients	*Terminal illness or vegetative state*	*Clarified must be on life support*
State role	Minimal	Procedural safeguards	*Emphasized government care responsibility*

Table 1: Changes Brought by the Harish Rana Case 2026 in India.[11]

The Court emphasised that decisions regarding withdrawal of life-sustaining treatment must be accompanied by strict procedural safeguards. These safeguards were originally considered in the case of *Common Cause (2018)* and later streamlined in the proceedings of *Common Cause (2023)*. The procedural framework requires the formation of a 'Primary Medical Board', consisting of physicians directly involved in the patient's treatment, and a 'Secondary Medical Board', consisting of independent medical experts. These boards must evaluate the patient's medical condition and determine whether continuation of treatment serves any therapeutic purpose. In the present case, both boards independently concluded that the patient's condition was irreversible and that recovery was medically impossible. The Court also recognised that practical challenges arise when patients receive long-term care at home rather than in hospitals. The judgment therefore clarified that medical boards may evaluate patients in home-care settings where necessary.

Despite recognising passive euthanasia through judicial interpretation, the Court expressed concern about the '*absence of a comprehensive statutory framework*' regulating end-of-life decisions. The Court noted that various findings issued by the Indian Law Commission have recommended legislation on Euthanasia and end-of-life care. However, Parliament has not yet enacted a comprehensive law in this area. The Court therefore urged the legislature to enact clear statutory provisions addressing issues such as advance medical directives (living wills), withdrawal of life-sustaining treatment, palliative care and

[11] Harish Rana v. UOI & Ors., 2026 INSC 222; M.A No. 2238 of 2025 in SLP (Civil) No. 18225 of 2024.

legal protection for physicians. Such legislation would reduce uncertainty among medical practitioners and ensure consistent implementation of constitutional principles[12].

COMPARATIVE JURISPRUDENCE: FOREIGN CASE LAWS REFERRED BY THE COURT

In the case of Harish Rana, the jurists undertook a detailed comparative analysis of international jurisprudence concerning terminally ill and giving up of life-sustaining therapy. The Court examined decisions from several jurisdictions to understand how courts determine whether continuing medical treatment serves the good interests of the vegetative state person. The reliance on foreign precedents reflects the global nature of ethical and constitutional debates surrounding end-of-life decision making.

The Apex court of India while deciding Harish Rana v. Union of India, relied on comparative jurisprudence from several countries where euthanasia is not completely legalised but allowed in some cases. The court drew upon these precedents to clarify the legality of withdrawing life-sustaining treatment and the constitutional idea of the right to die with dignity. It discussed the Britains Airedale NHS case in which the House of Lords permitted withholding artificial nutritional assistance and hydrate from a patient in a chronic comatose state, holding that such withdrawal constitutes discontinuation of medical treatment rather than an act intended to cause death. The Apex Court also looked in subsequent UK decisions, such as County Durham and Darlington NHS Foundation Trust v. PP (2014), Cumbria NHS Clinical Commissioning Group case of 2016, NHS Windsor and Maidenhead Clinical Commissioning Group v. SP case of 2018, Hillingdon Hospitals NHS Foundation Trust case of 2023, and NHS South East London Integrated Care Board v. JP case in 2025, reaffirmed the “best interests of the patient” principle and the judicial role in supervising end-of-life decisions[13].

The SC of India also analysed the case of the American Apex Court which recognised that individuals have a constitutional right to refuse life-sustaining medical treatment in the suits of *Cruzan v. Director, Missouri Department of Health*[14]. In the proceedings of *Vacco v. Quill*, the Court upheld the prohibition on physician-assisted suicide but distinguished it from the lawful withdrawal

[12] "Constitutional & legal protection for life support and limitation in India.", Mani, R. K, IJPC 2015.

[13] https://www.judiciary.uk/judgments. NHS South East London Integrated Care Board v JP & Ors [2025]

[14] "Beyond the Cruzan case: the US Supreme Court and medical practice." By Lo, Bernard, and Robert, ‘Annals of internal medicine’ 114.10 (1991): 895-901.

of medical treatment[15]. In the case of Rodriguez v. Attorney General of Canada, the Canadian Court upheld restrictions on assisted suicide while acknowledging the ethical complexity of end-of-life decisions[16]. The Judges of SC of India also discussed about other International Jurisdictions judgements of courts of Ireland, Australia, and New Zealand which have similarly recognised patient autonomy and allowed withdrawal of medically futile treatment when it no longer serves the patient's welfare.[17]

These around the globe judgments highlight fundamental norms, including respect for patient autonomy, the use of the best-interest criteria, a clear distinction between active and passive euthanasia, and court review of end-of-life decisions. Using these powers, the highest court enhanced the constitutional legitimacy of one's right to perish with respect under Article 21.

Country / Jurisdiction	**Case Law**	**Key Legal Principle**	**Relevance to Harish Rana v. Union of India**
United Kingdom	Airedale NHS Trust vs. Bland (1993)	Stopping artificial nourishment and hydration from a ill person in a continuous long period of coma state is considered discontinuation of medical treatment rather than intentional killing.	Established the gap between the end of therapy and actively choosing death..
United Kingdom	NHS Southeast London Integrated Care Board vs. JP (2025)	Reaffirmed judicial oversight and patient welfare in end-of-life decisions.	Shows continuing development of the best-interest standard.

[15] "Vacco v. Quill and the Debate over Physician-Assisted Suicide: Is the Right to Die Protected by the Fourteenth Amendment.", Arestad, Kim C., (1998): 511.
[16] Avila, Daniel. "Rodriguez v. Attorney General of Canada." Issues L. & Med. 9 (1993): 389.
[17] Supreme Court Judgement 11-Mar-2026.pdf Pg No 128-230.

United States of America	Cruzan vs. Director, Missouri Department of Health (1990)	Held human beings have the constitutional right to deny life-sustaining medical care.	Influenced recognition of patient autonomy in medical decisions.
United States	Vacco vs. Quill (1997)	Upheld prohibition on physician-assisted suicide but distinguished it from withdrawal of medical treatment.	Clarified the difference between active euthanasia and passive euthanasia.
Canada	Rodriguez vs. Attorney General of Canada (1993)	Upheld restrictions on assisted suicide while acknowledging ethical complexities in end-of-life decisions.	Demonstrated balancing between autonomy and the authority duty of protecting life..
Other Jurisdictions	Ireland, Australia, and New Zealand cases	Courts recognise patient autonomy and allow withdrawal of medically futile treatment.	Shows emerging global consensus on the best interests and dignity of the patient.

Table 2: Comparative table summarising the international jurisprudence referred to in *Harish Rana v. Union of India* regarding The ending of life-saving medical services and the right to choose death with dignity.[18]

CONCLUSION

The decision in Harish Rana v. Union of India (2026) is a historical turning point in India's emerging jurisprudence on euthanasia

[18] Dr. Anuradha & Paras Pradhan, EUTHANASIA: AT INDIAN & WORLD CONTEXT, 2021, Notion Press.

and end-of-life decisions. The Apex Court clarified that life-sustaining measures such as artificial nourishment and hydration are considered medical care and may be discontinued when they are no longer serving the patient's best interests. At the same time, the Court made a clear gap between indirect euthanasia, which is constitutionally acceptable with appropriate precautions, and active euthanasia, which is still illegal. The verdict also emphasized the significance of procedural safeguards, such as independent medical boards and family viewpoints in end-of-life decisions. These safeguards ensure that decisions to withdraw treatment are made with caution, transparency, and respect for the dignity of the patient. Furthermore, the Court’s engagement with comparative jurisprudence demonstrates the universal nature of ethical dilemmas surrounding end-of-life care. By drawing upon international precedents, the Court reinforced the legitimacy of its constitutional reasoning and aligned Indian law with global medical ethics.

However, the verdict shows a significant void in India's legal system governing euthanasia. The lack of complete law continues to cause uncertainty for patients, families, and medical professionals. Judicial guidelines, while useful, cannot totally replace a clear statutory framework. Finally, the Harish Rana case emphasizes the importance of striking a compromise between two essential values: the sanctity of life and personal dignity. Recognizing that dignity may necessitate allowing nature to take its course in certain circumstances, the Supreme Court reaffirmed that the Constitution protects not just the right to life, but also the right to die with dignity.

B. R. Ambedkar's phrase, "Life should be great rather than long," is frequently cited in legal study to emphasize the importance of quality of life and dignity above longevity. As Mahatma Gandhi stated in On Death and Dignity, "Death is not the greatest loss in life, the greatest loss is what dies within us while we are alive." Most of the time this legal theory is used to argue that long-term suffering or loss of autonomy diminishes the basic dignity of life. In the Britain landmark case of Airedale NHS Trust 1993, Lord Mustill judgment stated that "If the law compels a patient to endure what he reasonably considers an intolerable existence; the law itself becomes inhumane”. It supports the concept that the law should respect patients' autonomy and dignity at the end of life.

This case also serves as a reminder that lawmaking by Parliament is not the only way to enhance constitutional values. In this process, the court is crucial, especially when it deals with delicate and complicated matters, even if they only impact a small portion of the population. In these situations, judicial action becomes

crucial for the defence and advancement of basic rights. It highlights the need for careful constitutional treatment because they raise fundamental issues of humanity's worth, autonomy, and existence. The ruling also acts as a normative reminder to the legislature of its duty to pass comprehensive and clear laws regarding the issues of life and death. It emphasizes the necessity of prompt legislative action as opposed to an excessive dependence on court decisions in this morally and legally vital area.

This Harish Rana case therefore stands as an important contribution to evolving Indian constitutional law, Medical Jurisprudence and Human rights discourse in India. It advances the ongoing effort to reconcile legal doctrine with the ethical realities of modern medical practice and provides a framework for future developments in the law governing end of life care thereby upholding the spirit of Article 21. It was a sad moment for judges but also decisive moment in constitutional jurisprudence and thereby it reminds us that dignity must endure even at the threshold of life and death.