

The Right to Live with Dignity: Rethinking the Constitutional Boundaries of Passive Euthanasia

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Abstract—The Supreme Court's decision in *Harish Rana v. Union of India*, 2026 INSC 222, examines the constitutional boundaries governing the withdrawal of life-sustaining treatment from a patient in a permanent vegetative state. The case raises significant questions concerning the status of clinically assisted nutrition and hydration (CANH), the meaning of the best-interest standard, and the relationship between the right to life, dignity and autonomy under Article 21 of the Constitution of India. This commentary traces the constitutional development of the right to die with dignity through *P. Rathinam*, *Gian Kaur*, *Aruna Ramachandra Shanbaug* and *Common Cause*, and analyses the Court's treatment of CANH as medical treatment in the circumstances of the case. It further examines the Court's approach to medical futility, substituted judgment, family consultation and institutional safeguards. The commentary argues that the judgment's significance lies in shifting the legal inquiry from an abstract question of whether a person should live or die to the more specific question of whether continued medical intervention remains justified in the circumstances of the patient.

Index Terms—Article 21, autonomy, best interests, CANH, dignity, end-of-life care, passive euthanasia.

I. THE QUESTION OF DIGNITY AT LIFE'S END

The right to life under Article 21 of the Constitution of India has never been understood merely as a right to remain biologically alive. Over time, the scope of Article 21 has expanded to include dignity, autonomy and the conditions necessary for a meaningful human existence. The difficult question arises when continuing medical treatment keeps a person

biologically alive but offers no prospect of recovery or meaningful interaction.

This exact question makes our case. A judgment passed on 11 March 2026 answers our questions. The case is of *Harish Rana* a young man, who was in a permanent vegetative state (PVS) for more than 13 years because of a severe brain injury. He was completely dependent on Clinically Assisted Nutrition and Hydration (CANH), given by a surgically inserted PEG tube.¹

The importance of the case does not simply talk about permitting the withdrawal of CANH it attempts to talk about the most important constitutional and medical boundaries where the withdrawal of life-sustaining treatment can take place.

The consideration of whether CANH should be regarded as medical treatment and, whether it could be withdrawn under the framework was established in *Common Cause v. Union of India*.² The examination of the meaning of the “best interest of the patient” standard when the patient is unable to make decisions independently.³

The analysis therefore focuses on three interconnected questions: How CANH should be characterised within the existing legal framework governing withdrawal of life-sustaining treatment; How the best-interest standard should operate where the patient cannot communicate their wishes; How the judgment balances the constitutional values of life, dignity and autonomy against the need for institutional safeguards.

¹ *Harish Rana v. Union of India*, 2026 INSC 222, Misc. Application No. 2238 of 2025 in SLP (C) No. 18225 of 2024 (Mar. 11, 2026).

² *Common Cause (A Regd. Soc'y) v. Union of India*, (2018) 5 SCC 1.

³ *Harish Rana v. Union of India*, 2026 INSC 222, para 306–12.

II. THE CONSTITUTIONAL EVOLUTION OF THE RIGHT TO DIE WITH DIGNITY

The constitutional position regarding the right to die has a really interesting history of a transformation. This development can be traced through a series of decisions that progressively clarified the relationship between the right to life, dignity and end-of-life medical treatment.

In *P. Rathinam v. Union of India*, a two-judge bench came to the conclusion that the right to life under Article 21 included a right not to live, and declared Section 309 of the Indian Penal Code unconstitutional.⁴

Later came another case to establish its base.....

In *Gian Kaur v. State of Punjab*, P. Rathinam case was overruled and held that the right to life could not be understood as including a right to terminate one's life. at the same time, one important distinction was given between the right to die and the right to die with dignity at the end of one's natural life. This clarification later became central to Indian euthanasia jurisprudence.⁵

Then came one of the most interesting cases in our history of euthanasia.....

In *Aruna Ramachandra Shanbaug v. Union of India*. The acknowledgment of the possibility of passive euthanasia in limited circumstances which permitted withdrawal of life-sustaining treatment subject to procedural safeguards. This one acknowledgment shifted the entire debate from whether death could ever be permitted towards the circumstances in which treatment could lawfully be withdrawn.⁶

This development was placed on a stronger constitutional footing in another case

In *Common Cause v. Union of India*. It was accepted that the right to die with dignity forms a part of the right to life under Article 21, acceptance of advance

medical directives and also laid down procedural safeguards governing the withholding or withdrawal of medical treatment.⁷ These guidelines were subsequently modified in *Common Cause v. Union of India in 2023*.⁸

Harish Rana must be understood as a continuing of the legal development. It does not overturn the earlier cases. Instead, it deals with a practical question that were resolved: Whether CANH, which may appear similar to ordinary feeding, should nevertheless be treated as medical treatment capable of withdrawal?⁹

III. THE CASE BEHIND THE CONSTITUTIONAL QUESTION

Harish Rana suffered a severe brain injury after falling from the fourth floor from his paying guest room in August 2013. Since then, he has been in a permanent vegetative state. His condition made him become in a state where he was not aware of his surroundings, inability to communicate and complete absence of any reasonable prospect of neurological recovery.

He was maintained through several forms of medical support, including CANH administered through a PEG tube. His parents and other family members approached the Supreme Court seeking permission for withdrawal of CANH with the framework in *Common Cause*. The medical boards found out that Harish was in an irreversible PVS and a continuous CANH was necessary for his survival, it would not improve his medical condition or repair his underlying brain damage.¹⁰

This entire scenario raised two connected questions. Could CANH be classified as “medical treatment” rather than ordinary food and water? If it was medical treatment, could its withdrawal be justified on the basis of the patient's best interests?

These questions were very important to answer as classifying CANH as ordinary care would make its withdrawal legally and conceptually different from

⁴ P. Rathinam v. Union of India, (1994) 3 SCC 394, para 107–109.

⁵ Gian Kaur v. State of Punjab, (1996) 2 SCC 648, para 22–26.

⁶ Aruna Ramachandra Shanbaug v. Union of India, (2011) 4 SCC 454, para 106–13, 127–32.

⁷ Common Cause (A Regd. Soc’y) v. Union of India, (2018) 5 SCC 1, para 191–98.

⁸ Common Cause (A Regd. Soc’y) v. Union of India, (2023) 14 SCC 131.

⁹ Harish Rana v. Union of India, 2026 INSC 222, para 114–15, 302–05.

¹⁰ Harish Rana v. Union of India, 2026 INSC 222, para 16–17.

withdrawing medical treatment. Treating CANH as medical treatment would bring it within the safeguards governing withdrawal of life-sustaining treatment.

IV. THE COURT'S CONSTITUTIONAL FRAMEWORK

A. Article 21: Life, Dignity and Autonomy

The significance of dignity under Article 21 is particularly important in this context. The right to life is not merely a prohibition against physical deprivation of life; it also protects the individual's dignity and autonomy.¹¹ But recognising dignity does not mean that every person has an unrestricted constitutional entitlement to choose death.¹²

The judgment maintains a very important distinction between actively causing death and permitting death to occur following the lawful withdrawal of medical treatment. The latter is justified not by a desire to cause death, but by the recognition that medical treatment may cease to provide a therapeutic benefit and may no longer be in the patient's best interests.¹³

This distinction is essential because otherwise the withdrawal of treatment could incorrectly be equated with active euthanasia. In passive euthanasia, death results from the underlying medical condition after treatment is withdrawn; the medical intervention is not replaced by an intentional act designed to cause death.¹⁴

B. CANH: Medical Treatment or Basic Care?

At first glance, nutrition and hydration appear to be different from ventilators or medication. Food and water are usually considered to be basic human necessities. But the argument that CANH ceases to be a medical treatment merely was rejected because it does provide nutrition and hydration.¹⁵

The main thing was focused on was the manner in which CANH was administered. In Harish Rana's case, nutrition and hydration were provided in medically prescribed quantities through a surgically inserted PEG tube. The administration required medical supervision, clinical decision-making, periodic evaluation and management of possible complications.¹⁶

Hence it was held that CANH, constituted as medical treatment and could be considered for withdrawal under the Common Cause framework.¹⁷

The better interpretation is that CANH should not automatically be classified as medical treatment in every circumstance. Instead, its classification must depend upon the nature of the intervention, the medical circumstances of the patient, the manner of administration and the extent of continuing clinical supervision.

C. The Best Interest of the Patient and Medical Futility

The contribution of Harish Rana is arguably the detailed discussion of the "best interest of the patient" principle.¹⁸

Clarification of the relevant question went from whether it is in the patient's best interests to die, to Whether it is in the patient's best interests for life to be prolonged through continued medical treatment.¹⁹

This distinction is crucial as it prevents the best-interest principle from becoming a general justification for ending a patient's life. Instead, the inquiry remains focused on whether the particular treatment should continue.²⁰

A rigid definition of best interests was rejected. It was said that both medical and non-medical considerations must be examined. These may include the patient's

¹¹ Francis Coralie Mullin v. Administrator, Union Territory of Delhi, (1981) 1 SCC 608, para 6–8; K.S. Puttaswamy v. Union of India, (2017) 10 SCC 1, para 298–99.

¹² Gian Kaur v. State of Punjab, (1996) 2 SCC 648, para 22–26.

¹³ Harish Rana v. Union of India, 2026 INSC 222, para 303–12.

¹⁴ Harish Rana v. Union of India, 2026 INSC 222, para 303–05; Aruna Ramachandra Shanbaug v. Union of India, (2011) 4 SCC 454, para 104–13.

¹⁵ Harish Rana v. Union of India, 2026 INSC 222, para 294–305.

¹⁶ Harish Rana v. Union of India, 2026 INSC 222, para 303–05.

¹⁷ Harish Rana v. Union of India, 2026 INSC 222 305, 312.

¹⁸ Harish Rana v. Union of India, 2026 INSC 222, 230–33

¹⁹ Harish Rana v. Union of India, 2026 INSC 222 para 307

²⁰ Harish Rana v. Union of India, 2026 INSC 222 para 306–12

wishes, values, beliefs, welfare and likely attitude towards treatment²¹

A method called balance sheet was approached to adopt decision-makers to weigh the potential benefits of continuing treatment against its burdens. These burdens may include physical suffering, invasiveness, indignity, psychological distress and the effect of prolonged treatment on the patient's lived experience.²²

A treatment may technically keep a patient's biological functions operating while providing no meaningful therapeutic benefit. It was later acknowledged that preservation of biological life, supported by a strong presumption is not the only consideration relevant to best interests²³

The term “futility” should not be treated as an independent licence to withdraw treatment. It must be assessed as part of the broader best-interest inquiry. This is an important safeguard because medical judgments concerning prognosis and benefit are not always absolute²⁴.

D. Withdrawal of Treatment Versus Intentionally Causing Death

The reasoning keeps the conceptual distinction between passive euthanasia and active euthanasia. When medically futile treatment is withdrawn, the immediate cause of death remains the patient's underlying medical condition. The medical decision is to stop an intervention that no longer provides therapeutic benefit rather than to administer an intervention intended to cause death.²⁵

This distinction also protects medical practitioners. Doctors are not required to continue treatment indefinitely merely because stopping it will result in death. At the same time, they cannot withdraw treatment simply because they consider a patient's life to be of insufficient quality.²⁶

The best-interest framework therefore functions as a middle ground between two extremes: an absolute duty to preserve biological life at all costs and an unrestricted right to terminate life.²⁷

V. AUTONOMY, ADVANCE DIRECTIVES AND END-OF-LIFE DECISIONS

Common Cause recognised advance medical directives as an important mechanism through which an individual can exercise autonomy before becoming incapacitated. Harish Rana builds upon this understanding while recognising that not every patient will have executed such a directive.²⁸

In such circumstances, decision-makers may have to consider what the patient would have wanted. The substituted judgment forms a part of the best-interest inquiry, although it cannot operate as an independent or overriding standard.²⁹

This is an important limitation. A surrogate should not be permitted to impose personal preferences merely because the patient cannot object. The focus must remain on the patient's interests, wishes, values and welfare.³⁰

At the same time, this raises a difficult philosophical problem. How can a court or medical board reliably determine the wishes of a person who can no longer communicate? Family members may provide valuable information, but their own emotional interests may unconsciously influence their assessment.

The safeguards developed in *Common Cause* and refined in Harish Rana are therefore essential. Decisions concerning withdrawal of life-sustaining treatment cannot rest upon a single individual's opinion. They require medical evaluation, institutional

²¹ Harish Rana v. Union of India, 2026 INSC 222 para 230–33, 306–12.

²² Harish Rana v. Union of India, 2026 INSC 222 para 230–33.

²³ Harish Rana v. Union of India, 2026 INSC 222 para 230–33, 309–12.

²⁴ Harish Rana v. Union of India, 2026 INSC 222 para 230–33, 309–12.

²⁵ Harish Rana v. Union of India, 2026 INSC 222, para 303–05; Aruna Ramachandra Shanbaug v. Union of India, (2011) 4 SCC 454, para 104–13.

²⁶ Harish Rana v. Union of India, 2026 INSC 222, para 306–12.

²⁷ Harish Rana v. Union of India, 2026 INSC 222, para 230–33, 306–12.

²⁸ *Common Cause (A Regd. Soc’y) v. Union of India*, (2018) 5 SCC 1, para 191–98; Harish Rana v. Union of India, 2026 INSC 222, para 306–12.

²⁹ Harish Rana v. Union of India, 2026 INSC 222, para 230–33, 306–12.

³⁰ Harish Rana v. Union of India, 2026 INSC 222, para 230–33, 306–12.

safeguards and consideration of both medical and non-medical circumstances.³¹

VI. CRITICAL ANALYSIS: HAS HARISH RANA FULLY RESOLVED THE PROBLEM?

The judgment in *Harish Rana v. Union of India* provides important clarification on the withdrawal of life-sustaining treatment, particularly in relation to CANH and the best-interest standard. However, the judgment does not eliminate all uncertainty surrounding end-of-life decision-making. Its reasoning leaves several questions that may become significant in future cases involving different medical circumstances, competing assessments of treatment, or patients who have not expressed their wishes in advance.

A. The Context-Dependent Classification of CANH

The classification of CANH as medical treatment is context-dependent. The reasoning is particularly convincing in *Harish Rana's* case because CANH was administered through a PEG tube, in medically prescribed quantities and under continuing medical supervision.

However, future cases may involve different methods of feeding or different levels of medical intervention. The legal framework must avoid treating every form of nutrition and hydration as equivalent.³²

This contextual approach is important because an overly broad interpretation could blur the distinction between ordinary care and medical treatment. At the same time, treating CANH merely as food and water in every circumstance could prevent the legal framework from recognising situations in which nutrition and hydration function as a medically administered life-sustaining intervention. *Harish Rana* therefore provides a basis for a fact-sensitive approach rather than a universal classification of CANH.

B. Medical Futility and the Problem of Clinical Uncertainty

The concept of medical futility remains difficult to apply. The court correctly avoids treating futility as a simple mathematical formula. Yet medical professionals may disagree about whether a treatment provides therapeutic benefit, particularly where prognosis is uncertain. The possibility of disagreement makes independent medical review and procedural safeguards especially important.³³

The distinction is particularly important in constitutional terms. A decision that treatment no longer provides sufficient medical benefit is different from a judgment that the patient's life itself lacks sufficient value. The former concerns the appropriateness of a medical intervention; the latter would risk placing an impermissible value judgment upon the patient's life. The best-interest framework must therefore remain focused on the treatment and the patient's circumstances rather than on an assessment of whether the patient's life is worth preserving.

C. Autonomy, Substituted Judgment and Best Interests

The balance between autonomy and best interests remains complex. Autonomy strongly supports respecting an individual's previously expressed wishes, but an incompetent patient's current interests may not always perfectly correspond with what the patient might have decided in the past. *Harish Rana* attempts to resolve this tension by making substituted judgment a component of, rather than a replacement for, the best-interest standard.³⁴

This reveals a broader tension within the framework: autonomy is recognised as a constitutional value, but its exercise may depend upon institutional decision-making once the patient becomes incapable of communicating. The safeguards surrounding end-of-life decisions are therefore necessary to protect autonomy from being replaced by the preferences of others, but those same safeguards also demonstrate that autonomy cannot always operate as an

³¹ *Common Cause (A Regd. Soc'y) v. Union of India*, (2018) 5 SCC 1; *Common Cause (A Regd. Soc'y) v. Union of India*, (2023) 14 SCC 131; *Harish Rana v. Union of India*, 2026 INSC 222, para 306–12.

³² *Harish Rana v. Union of India*, 2026 INSC 222, para 294–305.

³³ *Harish Rana v. Union of India*, 2026 INSC 222, para 230–33, 306–12.

³⁴ *Harish Rana v. Union of India*, 2026 INSC 222, para 230–33, 306–12.

independent and immediately exercisable right in cases involving an incapacitated patient.

D. Judicial Oversight and the Need for a Clearer Legal Framework

The judgment highlights a broader institutional problem. Courts are being required to resolve questions that involve medicine, ethics, family relationships and constitutional law. Judicial intervention may be necessary in the absence of comprehensive legislation, but long-term regulation of end-of-life decisions should ideally be supported by a clear statutory framework.³⁵

The practical difficulties involved in implementing the Common Cause guidelines, the judgment attempts to streamline the existing framework and provide greater clarity to medical boards, families and doctors.³⁶

This is one of the most important aspects of *Harish Rana*. Its contribution lies not merely in the outcome for one patient, but in reducing uncertainty for future cases.³⁷

E. The Unresolved Constitutional Tension

These issues demonstrate that *Harish Rana* does not resolve the broader tension between preservation of life, patient autonomy and the limits of medical intervention. Instead, the judgment provides a framework through which that tension can be managed in individual cases.

Its most significant contribution lies in shifting the focus away from the abstract question of whether a person should be allowed to die and towards the more specific question of whether continued medical intervention remains justified in the circumstances of that patient. This approach allows dignity and autonomy to remain relevant without converting them into an unrestricted entitlement to terminate life.

At the same time, the framework depends heavily upon the quality of medical evidence, the

independence of decision-makers and the proper application of the best-interest standard. The effectiveness of the constitutional protection recognised in *Harish Rana* will therefore depend not only upon the principles stated by the Court but also upon how consistently those principles are applied by medical institutions, families and future courts.

VII. CONCLUSION

Harish Rana v. Union of India represents an important stage in the development of India's constitutional law on death and dignity.³⁸

The judgment does not create an unrestricted right to die. Instead, it operates within the constitutional framework developed through *Gian Kaur*, *Aruna Shanbaug* and *Common Cause*. Its importance lies in clarifying the circumstances in which withdrawal of life-sustaining treatment may be compatible with Article 21.³⁹

By recognising CANH as medical treatment in the circumstances before it, the Court brought such treatment within the existing framework governing withdrawal of medical intervention. More significantly, the Court provided a detailed explanation of the best-interest principle and emphasised that the inquiry must consider both medical and non-medical factors.⁴⁰

The judgment's treatment of dignity is equally significant. Dignity does not mean that death should be preferred over life. Rather, dignity requires the law to recognise that medical treatment should not necessarily be continued indefinitely when it no longer serves a therapeutic purpose and merely prolongs an irreversible condition.⁴¹

Harish Rana attempts to strike a difficult constitutional balance: preserving the sanctity of life while respecting individual dignity, autonomy and the limits of medical intervention. Its greatest contribution may

³⁵ *Harish Rana*, 2026 INSC 222. Para 306–12; *Common Cause (A Regd. Soc'y) v. Union of India*, (2023) 14 SCC 131.

³⁶ *Common Cause (A Regd. Soc'y) v. Union of India*, (2023) 14 SCC 131; *Harish Rana v. Union of India*, 2026 INSC 222, para 306–12.

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⁴⁰ *Harish Rana v. Union of India*, 2026 INSC 222, para 303–12.

⁴¹ *Harish Rana v. Union of India*, 2026 INSC 222, 230–33, 306–12.

therefore be its insistence that the question is not simply whether a person should live or die, but whether continued medical intervention genuinely serves that person's interests.⁴²

The constitutional question is not whether death should be preferred to life. It is whether the law should require the continuation of a medical intervention when that intervention no longer serves the interests of the person whose life it is intended to preserve. By approaching the issue through dignity, autonomy and best interests, Harish Rana moves the debate away from an abstract opposition between preserving life and permitting death. It instead recognises that, at the end of life, the constitutional protection of life may also require attention to the manner in which that life is prolonged and to whether continued medical intervention remains consistent with the dignity and interests of the individual.⁴³

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⁴² Harish Rana v. Union of India, 2026 INSC 222, para 230–33, 306–12.

⁴³ Harish Rana v. Union of India, 2026 INSC 222, para 303–12