The Indian Journal for Research in Law and Management

Open Access Law Journal – Copyright © 2025

Editor-in-Chief – Dr. Muktai Deb Chavan; Publisher – Alden Vas; ISSN: 2583-9896

FROM PASSIVE EUTHANASIA TO WITHDRAWAL OF TREATMENT: THE CLINICAL TURN IN INDIA'S RIGHT TO DIE WITH DIGNITY IN HARISH RANA V. UNION OF INDIA

Jagriti Pandey

1. INTRODUCTION

India's end-of-life jurisprudence has advanced through a halting sequence of constitutional declarations — from *Gian Kaur*'s recognition that Article 21 embraces a dignified death,[1] through *Aruna Shanbaug*'s tentative sanction of passive euthanasia,[2] to the Constitution Bench's mature framework in *Common Cause* (2018) and its 2023 procedural refinement.[3][4] Yet each left the ordinary caregiver stranded: the guidelines presupposed a hospitalised patient and an institutional trigger, offering no route for the many Indians sustained on artificial feeding at home. *Harish Rana* is the first occasion on which the *Common Cause* mechanism has been applied in its full measure, and Pardiwala, J. seizes it not merely to grant relief but to re-engineer the framework itself.[5] This commentary argues that the judgment's enduring contribution lies less in what it permits than in how it reasons: by relabelling "passive euthanasia" as the "withdrawal or withholding of medical treatment" and embedding that move within a rigorously comparative "best interests" inquiry, the Court converts a fraught moral controversy into an administrable clinical-legal protocol that finally reaches the home-cared, non-terminal patient.

---

[1] Gian Kaur v. State of Punjab, (1996) 2 SCC 648 (India).

[2] Aruna Ramchandra Shanbaug v. Union of India, (2011) 4 SCC 454 (India).

[3] Common Cause (A Registered Society) v. Union of India, (2018) 5 SCC 1 (India) [hereinafter Common Cause 2018].

[4] Common Cause (A Registered Society) v. Union of India, M.A. No. 1699 of 2019 in W.P. (C) No. 215 of 2005 (India Jan. 24, 2023) (order modifying the Common Cause Guidelines) [hereinafter Common Cause 2023].

[5] Harish Rana v. Union of India, 2026 INSC 222 (India).

2. FACTUAL MATRIX

The material facts are stark. The applicant, now 32, was a twenty-year-old B.Tech student when, in August 2013, he fell from the fourth floor of his lodging and sustained a diffuse axonal injury. Thirteen years on, two government disability certificates record a persistent vegetative state (PVS) with complete sensorimotor dysfunction, quadriplegia, and 100% permanent physical disability. He is sustained by clinically assisted nutrition and hydration (CANH) delivered through a surgically placed PEG tube — replaced bi-monthly — alongside a tracheostomy and urinary catheter. Critically for the Court's later analysis, he retains intact brainstem function and breathes spontaneously; he is not "mechanically" ventilated. He exhibits no awareness of his surroundings, cannot signal hunger or discomfort, and has shown no neurological improvement despite years of devoted home nursing by his mother. Both a primary medical board and an AIIMS-constituted secondary medical board certified that recovery is negligible and that continued CANH sustains biological existence without therapeutic benefit. The parents, brother, and sister — his sole caregivers — were unanimous that continuation served no purpose beyond prolonging his suffering.[6]

3. PROCEDURAL HISTORY

The procedural route is itself the problem the judgment solves. The family first approached the Delhi High Court in Writ Petition (C) No. 4927 of 2024, which was dismissed on the erroneous premise that, because the applicant was not being kept alive by a machine and could sustain himself without external aid, no relief could issue. The resulting Special Leave Petition (C) No. 18225 of 2024 was disposed of with a direction for State-funded home-based care, but with liberty to return. Deterioration — including a May 2025 hospitalisation and a fresh tracheostomy — prompted the present Miscellaneous Application No. 2238 of 2025.[7] The Supreme Court then constituted primary and secondary medical boards by orders of 26 November and 11 December 2025, thereby reconstructing at the apex level the very board mechanism that ought to have operated at the ground level. This history matters because it exposes the institutional lacuna at the heart of the case: for a patient cared for at home, no hospital exists to convene the boards, leaving families with no lawful pathway short of constitutional litigation — the precise gap the Court sets out to close.

[6] Harish Rana, supra note 1, ¶¶ 6–21.

[7] Id. ¶¶ 22–24 (submissions recording the Delhi High Court's dismissal of W.P. (C) No. 4927 of 2024 and the disposal of S.L.P. (C) No. 18225 of 2024).

4. LEGAL ISSUES

The Court distilled the dispute into four questions: (a) whether the administration of CANH is "medical treatment" amenable to withdrawal, or merely basic primary care that must always continue; (b) the meaning, scope, and contours of the "best interest of the patient" principle governing the withdrawal or withholding of treatment; (c) whether, on the facts, it was in Harish Rana's best interest that his life be prolonged by the continuation of treatment; and (d) the further steps to be taken once a withdrawal decision is reached, including the streamlining of the *Common Cause* Guidelines.[8]

5. HOLDING AND RATIO DECIDENDI

The Court answered the threshold question affirmatively: CANH, being prescribed, supervised, and periodically reviewed by trained professionals, is medical treatment and not mere sustenance — and it does not lose that character merely because it can be administered at home. On the merits, it held that continuation was not in the applicant's best interest, directed withdrawal, waived the ordinary thirty-day reconsideration period given the unanimity of all stakeholders, and ordered AIIMS to admit him to palliative care under a structured end-of-life plan.[9] The ratio's most consequential move, however, is terminological: the Court formally retires "passive euthanasia" as obsolete and confusing, reserving "euthanasia" for the still-impermissible active variety and substituting "withdrawing or withholding of medical treatment" for the passive form — a change it is careful to characterise as one of nomenclature, not of substance, so that the *Common Cause* safeguards continue to govern.[10]

6. DOCTRINAL REASONING

The constitutional anchor is Article 21: because the right to live with dignity encompasses dignity in dying, withdrawing futile treatment merely allows life's natural course to resume rather than extinguishing it.[11] Building on *Common Cause* (2018) and its 2023 modification, Pardiwala, J. undertakes an unusually wide comparative survey. From *Airedale v. Bland* he draws the "source of harm" test that reframes the act/omission divide;[12] from *In re Conroy* he imports the graduated limited-objective and pure-objective best-interests tests;[13] from *Re BWV*

[8] Id. ¶ 113 (issues for determination).
[9] Id. ¶¶ 300–305, 324, 327 (holding and final order).
[10] Id. ¶¶ 111–112 (clarification of nomenclature).
[11] INDIA CONST. art. 21; see Common Cause 2018, supra note 4.
[12] Airedale N.H.S. Trust v. Bland, [1993] A.C. 789 (H.L.) (appeal taken from Eng.).
[13] In re Conroy, 486 A.2d 1209 (N.J. 1985).

he adopts the Australian holding that PEG feeding is unquestionably a medical procedure;[14] and from *W v. M* he takes the treatment of minimally conscious patients.[15] The organising distinction is between active euthanasia, which introduces a new, external agency of harm and thereby *causes* death, and withholding treatment, which *allows* death to occur by permitting the underlying condition to run its course — an omission in substance even where a physical act, such as switching off a device, is involved.[16]

7. CRITICAL ANALYSIS

The judgment's internal architecture is impressive. It reconciles the sanctity of life with the quality of life not by subordinating one to the other but by routing both through dignity and bodily integrity: life carries a strong presumption of preservation, yet that presumption is displaceable where treatment has become futile and its imposition affronts the patient's dignity. The reasoning is at its most persuasive here.

It is more vulnerable where it transplants foreign doctrine. The Court embraces both the "balance sheet approach" and the "substituted judgment standard," yet the very authorities it relies upon place these in tension with PVS cases.[17] *Bland* held that no balancing is required in PVS, because wholly futile treatment yields no benefit to weigh; *W v. M* confined the balance-sheet exercise to minimally conscious (MCS) patients precisely because they retain some awareness. By applying a balancing exercise to a PVS patient, *Harish Rana* is doctrinally supererogatory — defensible as an added safeguard, but blurring the careful PVS/MCS line that its own sources draw. A second friction runs deeper: the Court champions a strong element of substituted judgment, asking what the patient would have wanted, even as the English authority it quotes expressly rejects substituted judgment in favour of an objective best-interests test. It resolves the contradiction only by subordinating substituted judgment to an "ultimate governing test" of best interests, which leaves the standard's true weight indeterminate. That indeterminacy is exposed by the facts. A man rendered incompetent at twenty, who never recorded any view on end-of-life care, cannot meaningfully be the subject of a genuine "substituted judgment"; the family's recollection that he loved football and the gym is, in truth, closer to *Conroy*'s pure-objective inquiry than to any reconstruction of his actual wishes.

[14] Re BWV; Ex parte Gardner [2003] VSC 173 (Austl.).

[15] W v. M, [2011] EWHC 2443 (Fam) (Eng.).

[16] Harish Rana, supra note 1, ¶¶ 293–294 (source-of-harm distinction between "causing death" and "allowing death to occur").

[17] Id. ¶¶ 310–316 (contours of the best-interest principle, the substituted-judgment standard, and the balance-sheet exercise).

Finally, the Court leaves much of the real-world execution open: the promised forty-eight-hour CMO nominations, district panels of practitioners, and magisterial intimations all presuppose administrative capacity the judgment cannot itself supply, and the thirty-day waiver is expressly confined to the unanimity of this case.

8. CONCLUSION

Harish Rana's immediate significance is practical: by confirming that CANH is treatment, that home care does not oust the framework, and that concurring medical boards need no judicial imprimatur, it removes much of the hesitation that has paralysed physicians on the ground. Its streamlined checkpoints — panels, timelines, and a defined role for the next of kin — supply the operational scaffolding that *Common Cause* lacked. Yet the Court is candid that judicial gap-filling is no substitute for law, renewing its plea for a comprehensive statute on end-of-life care.[18] Until Parliament answers, *Harish Rana* stands as the most workable articulation yet of a right India has long recognised in principle but rarely delivered in practice — precisely the clinical-legal translation this commentary identifies as its central achievement.

[18] Id. ¶¶ 322–323 (streamlining of the Common Cause Guidelines and the call for legislation).