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DIGNITY OVER PROLONGATION: A CASE COMMENTARY ON HARISH RANA v. UNION OF INDIA (2026 INSC 222)

Mannat Gothwal

I. INTRODUCTION

In Harish Rana v. Union of India[1], the Supreme Court of India delivered a judgment that is simultaneously a milestone in constitutional jurisprudence and a study in the limits of judge-made law. Decided on 11 March 2026 on Miscellaneous Application No. 2238 of 2025,[2] a two-judge bench comprising Justice J.B. Pardiwala and Justice K.V. Viswanathan became the first Indian court to sanction, in a live case, the withdrawal of life-sustaining treatment from a patient in a permanent vegetative state (PVS). The judgment constitutes the first full judicial implementation of the framework set out nearly eight years earlier in Common Cause v. Union of India,[3] the Constitution Bench decision that recognised the right to die with dignity as a facet of Article 21 of the Constitution of India.[4]

The case lies at the intersection of law and medicine, constitutional principles and clinical realities, compassion and procedural safeguards. This commentary examines the factual background, the arguments presented, the ratio decidendi, and the doctrinal consequences of the judgment. It concludes with a critical appraisal of the Court's reasoning and its broader implications for bioethics and constitutional law in India.

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[1] *Harish Rana v. Union of India & Ors.*, 2026 INSC 222 (India) [hereinafter *Harish Rana*].
[2] *Misc. Application No. 2238 of 2025 in SLP (C) No. 18225 of 2024 (India).*
[3] *Common Cause v. Union of India*, (2018) 5 S.C.C. 1 (India) [hereinafter *Common Cause*].
[4] *INDIA CONST. art. 21.*

II. FACTUAL MATRIX

Harish Rana was a twenty-year-old B.Tech student at Punjab University, Chandigarh, described by his family as physically active and brimming with purpose.[5] On 20 August 2013, he fell from the fourth floor of his paying-guest accommodation, sustaining a severe Diffuse Axonal Injury that left him in a state of permanent unconsciousness, 100 per cent quadriplegic with no capacity for voluntary movement, communication, or awareness.[6] For thirteen years, his parents provided round-the-clock nursing care, sustained by the hope of recovery that medical science ultimately confirmed could never arrive.[7]

Harish's sustenance was maintained entirely through Clinically Assisted Nutrition and Hydration (CANH) delivered via a percutaneous endoscopic gastrostomy (PEG) tube. Successive medical boards (both primary and secondary) unanimously concluded that his condition was irreversible and that continued treatment served no therapeutic purpose. His family, sharing this clinical assessment, petitioned the Supreme Court under Article 32 of the Constitution seeking judicial sanction to withdraw the PEG tube and allow their son a dignified death.[8]

III. ARGUMENTS ADVANCED

For the applicant,[9] it was contended that Article 21, read with the right to privacy and bodily integrity affirmed in K.S. Puttaswamy v. Union of India, protects not merely biological life but meaningful existence, and that compelling a person to endure existence devoid of all consciousness constitutes a violation of the very dignity that Article 21 is designed to protect. The applicant further argued that CANH administered through a PEG tube constitutes medical treatment, not basic nursing care and therefore falls squarely within the scope of the passive euthanasia framework recognised in Common Cause 2018. In the absence of an Advance Medical Directive (AMD), the unanimous view of the medical boards and the patient's family should be treated as sufficient for the application of the best interests standard.

[5] *Harish Rana*, supra note 1, ¶ 15.
[6] Id. ¶ 8.
[7] Id. ¶¶ 1–6.
[8] Id. ¶ 12.
[9] Id. ¶¶ 15–24.

The Union of India, while not contesting the constitutional principle,[10] urged the Court to ensure that robust procedural safeguards remained non-negotiable. It flagged the risk of misuse, particularly the danger of decisions being distorted by financial pressures, lack of insurance, or familial coercion and emphasised that the deliberate procedural complexity of the Common Cause guidelines was an essential bulwark against abuse. The State cautioned against allowing the best interests framework to become a vehicle for substituting family preferences for the objective interests of the patient.

IV. RATIO DECIDENDI

The Court's ratio may be distilled into four core propositions. First, it reaffirmed that the **right to life under Article 21 encompasses the right to die with dignity**.[11] Drawing on the foundational recognition in Gian Kaur v. State of Punjab[12] that for terminally ill patients or those in PVS the right to die with dignity is a part of the right to life, and the subsequent elaboration in Common Cause 2018, the Court held that this right is enforceable in practice not merely declaratory in aspiration.

Second, and most doctrinally significant, the Court held that **CANH delivered via a PEG tube is medical treatment**, not mere basic care and is therefore susceptible to withdrawal under the passive euthanasia framework.[13] This resolved a question left unanswered by Common Cause 2018, and the ruling brings India into alignment with the position taken by courts in England, Canada, and the European Union, which have uniformly classified PEG-administered nutrition as a medical intervention.

Third, the Court significantly developed the **'best interests' standard**. Prior to Harish Rana, that standard had been recognised but not elaborated. The judgment now requires a two-limb inquiry: an assessment of clinical futility and medical irreversibility, which is necessary but not sufficient; and a separate reconstruction of the patient's own values, wishes, and sense of dignity from the evidence of those who knew them.[14] Neither the clinical judgment of doctors nor the preferences of the family is determinative standing alone. The constitutional obligation, the Court held, is to assess the patient as an individual.

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[10] Id. ¶¶ 30–34.
[11] *Common Cause*, supra note 3, ¶ 199.
[12] *Gian Kaur v. State of Punjab*, (1996) 2 S.C.C. 648, ¶ 24 (India).
[13] *Harish Rana*, supra note 1, ¶ 148.
[14] Id. ¶ 233.

Fourth, the Court streamlined the **Common Cause procedural architecture** for patients receiving home-based care, directing that Chief Medical Officers in all districts maintain panels of registered medical practitioners for secondary medical boards, and directing High Courts to ensure that judicial magistrates are notified wherever medical boards are unanimous[15]. Applying this framework, the Court authorised withdrawal of CANH and directed AIIMS, New Delhi to formulate a comprehensive palliative and end-of-life care plan, emphasising that withdrawal must not amount to 'abandonment'.[16]

V. CRITICAL ANALYSIS

The judgment's greatest contribution lies in its transformation of the right to die with dignity from an abstraction into an enforceable entitlement. For over eight years following Common Cause 2018, the framework remained, in the words of one scholar, largely a **'paper tiger'** constitutionally recognised but procedurally inaccessible. Harish Rana demolishes that paradox by demonstrating that the right can be actualised in practice.

The doctrinal resolution of the CANH question is particularly welcome. The determination that PEG-administered nutrition is a medical intervention rather than a basic form of care akin to feeding by hand is not merely academic. It has immediate practical consequence: healthcare professionals can now withdraw CANH in appropriate circumstances without fear of criminal prosecution under the Bharatiya Nyaya Sanhita, 2023, provided the medical board mechanism is followed. This clarity reduces the chilling effect on physicians and makes the right to die with dignity a more accessible reality.

The elaboration of the best interests standard through a cross-jurisdictional analysis is also to be commended. By insisting on a dual inquiry 1. clinical and 2. value-based, the Court prevents the reduction of a profoundly human decision to a merely medical calculation. The requirement to reconstruct the patient's individual identity and values is an acknowledgement that dignity is inherently personal, not categorical.[17]

That said, the judgment is not without its tensions. The most searching critique concerns the Court's adoption of a non-voluntary best interests model where no Advanced Medical Directive exists and the patient's preferences are reconstructed through proxy evidence without a sufficiently demanding procedural architecture to guard against ableist assumptions

[15] Id. ¶ 247.
[16] Id. ¶ 275.
[17] *K.S. Puttaswamy v. Union of India*, (2017) 10 S.C.C. 1, ¶ 325 (India).

or socio-economic pressures shaping the outcome. The Union's concern about financial distress or lack of insurance impermissibly driving withdrawal decisions is real and not fully addressed by the Court's streamlining of board procedures. The risk of the framework being extended, in future cases, beyond paradigmatic **Persistent Vegetative State** situations to cases where recovery is unlikely but not impossible, cannot be discounted without clearer doctrinal thresholds.

Moreover, the relief was granted under Article 32 - an extraordinary constitutional remedy before the Supreme Court. As has been noted, this is not a mechanism easily available to the families of ordinary patients who cannot afford to litigate before the apex court. The right to die with dignity, if it is a genuine fundamental right, should not depend on the financial capacity to approach New Delhi. The Common Cause framework, despite its refinement in Harish Rana, continues to present formidable procedural hurdles for families operating without legal counsel.

The Court's strongly worded direction to Parliament to enact a comprehensive statute on end-of-life decision-making[18] is perhaps the most honest aspect of the judgment. It is an implicit acknowledgement that judge-made guidelines functioning as de facto legislation are an unsustainable constitutional arrangement. As the Court itself warned, in the absence of legislation, extraneous factors like financial distress, insurance gaps, familial dynamics will inevitably creep into decisions that are supposed to be governed solely by the patient's best interests.

VI. CONCLUSION

Harish Rana v. Union of India marks a quiet but profound moment in India's constitutional history. It moves the right to die with dignity from the realm of principle to the plane of practice. By classifying CANH as medical treatment, elaborating the best interests standard into a dual-limb inquiry, and strengthening the procedural infrastructure through which the right operates, the Court has made the passive euthanasia framework functional for the first time since its recognition in Common Cause 2018.

Yet the judgment also exposes the structural inadequacy of relying on the judiciary to do the work of the legislature. India's bioethics jurisprudence, ambitious and compassionate as it is, rests on a constitutional foundation that is humanly built but institutionally fragile. The

[18] *Harish Rana*, supra note 1, ¶ 280.

family's thirteen-year vigil, the medical boards' clinical honesty, and the Court's principled compassion converged in a single case. The real measure of the judgment will be how many families without legal representation, without proximity to the Supreme Court, and without financial resources are able to access the same dignified choice that Harish Rana's family finally received.

The Court, quoting an ancient Subhashita, noted that *mental anguish burns the living more devastatingly than any funeral fire*.[19] That insight deserves to inform not merely the adjudication of individual petitions, but the architecture of a statutory framework that Parliament has so far declined to provide. Until that framework arrives, Harish Rana stands as both a milestone and a reminder of how far India still has to travel.

TABLE OF AUTHORITIES

Cases

1. Harish Rana v. Union of India & Ors., 2026 INSC 222 (Supreme Court of India, 11 March 2026).

2. Common Cause v. Union of India, (2018) 5 SCC

3. Aruna Ramchandra Shanbaug v. Union of India, (2011) 4 SCC 454.

4. Gian Kaur v. State of Punjab, (1996) 2 SCC 648.

5. K.S. Puttaswamy v. Union of India, (2017) 10 SCC 1.

6. Francis Coralie Mullin v. Union Territory of Delhi, (1981) 1 SCC 608.

Constitutional and Legislative Provisions

7. Constitution of India, Article 21.

8. Constitution of India, Article 32.

9. Bharatiya Nyaya Sanhita, 2023.

[19] *Aruna Ramachandra Shanbaug v. Union of India*, (2011) 4 S.C.C. 454, ¶ 89 (India).