The Indian Journal for Research in Law and Management
Open Access Law Journal – Copyright © 2026
Editor-in-Chief – Dr. Muktai Deb Chavan; Publisher – Alden Vas; ISSN: 2583-9896

This is an Open Access article distributed under the terms of the Creative Commons Attribution-Non-Commercial-Share Alike 4.0 International (CC-BY-NC-SA 4.0) License, which permits unrestricted non-commercial use, distribution, and reproduction in any medium provided the original work is properly cited.

BETWEEN LIFE AND DIGNITY: A CASE COMMENT ON HARISH RANA v. UNION OF INDIA

~ Gargi Kolhe

INTRODUCTION

In earlier Indian jurisprudence, the discussion in end-of-life law was regarding whether the Constitution protects "right to die", it has now shifted towards how dignity can operate when medical treatment prolongs biological existence. *Harish Rana v. Union of India* (2026)[1] brings this question. Harish Rana had been in a vegetative state for more than thirteen years. He could neither communicate nor make decisions regarding his own treatment. Yet the Court looked at his wishes and values, while considering his welfare and best interests.

This creates the judgment's central challenge: how law preserves the patient's autonomy when they could not exercise it themselves. Court's response lies in the substituted judgment within the broader best-interests framework. This comment argues that this approach tries to preserve the autonomy even after ordinary exercise is not possible, while exposing an evidentiary difficulty: when another person reconstructs what the patient would have wanted, at which point the substituted judgment stops preserving the autonomy and instead becomes an attribution of it?

FACTS

Harish Rana was a 20-year-old B.Tech student when he fell from the fourth-floor of his paying-guest accommodation on 20 August 2013.[2] He suffered severe diffuse axonal brain injury and subsequently remained in a permanent vegetative state and was dependent on clinically assisted nutrition and hydration (CANH) through a PEG tube.[3]

---

[1] Harish Rana v. Union of India 2026 INSC 222.
[2] *Id.* ¶ 6.
[3] *Id*. ¶ 6-8, 12.

After the Delhi High Court dismissed his writ petition in 2024, the applicants filed an SLP before the Supreme Court.[4] The Court gave liberty to seek further directions.[5] Later, his parents filed a Miscellaneous Application, to assess the CANH under *Common Cause v. Union of India*.[6] The Primary and Secondary Medical Boards stated CANH could sustain the patient's survival but could not improve or repair his medical condition.[7]

ISSUES BEFORE THE COURT

1. Whether CANH is considered as "medical treatment", capable of lawful withdrawal?[8]

2. When the patient lacks decision-making capacity, what does the "best interests of the patient" actually mean?[9]

3. Whether continuation of CANH was in the patient's best interests?[10]

4. What safeguards and procedures must govern such withdrawal?[11]

Underlying these issues, there was a more difficult question: how can autonomy be preserved when the person concerned can no longer communicate?

CONTENTION OF THE PARTIES

Applicants: The applicants relied on the *Common Cause* framework and argued that CANH administered through a PEG tube is a life-sustaining treatment which can be withdrawn.[12] They argued that the question was not whether death was in the best interest of the patient but whether continuing CANH was in the best interest of the patient as his condition was irreversible and lacked therapeutic benefit.[13]

Union of India: The UOI agreed CANH administered through a medical device is considered as medical treatment.[14] They submitted, when the treatment is futile, withdrawal of such treatment falls within the recognised legal framework of *Common Cause*.[15] They

---

[4] *Id*. ¶ 3.
[5] *Id*. ¶ 4.
[6] *Id*. ¶ 4-5.
[7] *Id*. ¶ 14, 16.
[8] *Id*. ¶ 113 (1).
[9] *Id*. ¶ 113 (2).
[10] *Id*. ¶ 113 (3).
[11] *Id*. ¶ 113 (4).
[12] *Id*. ¶ 23 (d).
[13] *Id*. ¶ 23 (f)-(g).
[14] *Id*. ¶ 25 (b).
[15] *Id*. ¶ 25 (a).

relied on the findings of medical boards and supported withdrawal of CANH, subject to appropriate palliative care.[16]

JUDGMENT:

The Court held that CANH administered through PEG tube is "medical treatment" and can be withdrawn or withheld in appropriate cases.[17] According to the Court, the relevant question is not whether death itself is in the patient's best interest, but whether the continued treatment remains in those interests.[18]

The Court held, while inquiring into the "best-interests", both medical and non-medical factors are to be considered and patient's wishes, feelings, beliefs, values and welfare must also be considered.[19] But determining only the patient's wants does not become the entire basis for final decision, substituted judgment does not replace the final best-interests assessment.[20] Decision-makers have to balance the benefits of the continued treatment and its burden, including whether it serves any therapeutic purpose.[21]

Applying this framework, the Court concluded that CANH is no longer in Harish's best-interests and directed its withdrawal or withholding with appropriate palliative and end-of-life care.[22] It also clarified and streamlined the *Common Cause* framework, including mechanisms for constituting medical boards and reducing unnecessary judicial intervention, particularly when medical boards are unanimous.[23]

RATIO DECIDENDI

1. CANH administered through PEG tube is considered as "medical treatment", and therefore the same legal framework will be applied which governs the withdrawal or withholding of medical treatment.[24]

---

[16] *Id*. ¶ 25 (d), (f).
[17] *Id*. ¶ 242.
[18] *Id*. ¶ 233 (1).
[19] *Id*. ¶ 230-231.
[20] *Id*. ¶ 233 (7).
[21] *Id*. ¶ 233 (8).
[22] *Id*. ¶ 324, 327 (a), (c)-(d).
[23] *Id*. ¶ 322 (iv)-(vi), 327 (e).
[24] *Id*. ¶ 242-243.

2. The governing test will be the patient's "best interests", determined through a holistic assessment of the medical and non-medical factors. This includes the therapeutic purpose of the treatment and the suffering, welfare, wishes and values of the patient.[25]

3. Substituted judgment is a part of the best-interest inquiry, but it cannot replace it. The decision-makers must consider what the patient would have wanted if they had the decision-making capacity, but their reconstructed preference is not independently conclusive. The ultimate decision will be governed by the patient's best interest.[26]

CRITICAL ANALYSIS AND SIGNIFICANCE

The significance of the case lies in the understanding what happens to autonomy when it is practically unavailable. The Court answered this through substituted judgment: when the patient cannot express themselves, other persons need to reconstruct what the patient would have wanted. This is one way to preserve the agency of the patient. But at this point the judgment becomes vulnerable too.

Empirical evidence suggests that the moral basis for substituted judgment is unsound.[27] A person's values and actual choices are not necessarily the same. Someone may value their life, fear prolonged suffering or prefer limited medical intervention. That does not mean that the person has already decided what they will choose if they ever entered a permanent vegetative state. When a situation like that arises, another person may describe the values and character of the patient with confidence, but that does not provide complete certainty about what the patient would actually have chosen.

This distinction is especially important in the present case. If Harish did not provide any specific indications related to permanent unconsciousness, artificial nutrition or treatment withdrawal, then the decision-makers could only infer what he would have actually decided from his general values and beliefs. The more this inference extends, the more uncertain it becomes about whether the law is actually discovering the patient's choice or constructing a choice for the patient.

This is the unresolved point in the present case. The Court does not make the substituted judgment conclusive. The patient's best-interests takes precedence over their reconstructed

---

[25] *Id*. ¶ 230-231, 233 (3)-(4), (8).
[26] *Id*. ¶ 233 (7).
[27] Alexia M. Torke et al., Substituted Judgment: The Limitations of Autonomy in Surrogate Decision Making, PubMed Central (July 10, 2008), https://pmc.ncbi.nlm.nih.gov/articles/PMC2518005/.

preferences. This does not completely solve the underlying difficulty, rather it only changes the question. When a patient's wishes are uncertain, how much of the decision should constitute an exercise of the patient's autonomy and how much should be left to the decision-maker to assess what ought to be done for the patient?

This distinction matters because best interests can accommodate considerations to which autonomy cannot provide an answer. Medical futility, suffering, indignity and therapeutic burden may justify withdrawal, even if the patient's exact preference is not established. In decision-making, when these considerations play a major role, describing the outcome as an exercise of the patient's autonomy can obscure the actual decision-producing factors.

The procedural safeguards provided in the judgment cannot completely bridge the gap. Relatives can provide evidence regarding a patient's values and wishes, medical boards can determine a patient's prognosis, the therapeutic benefits of the treatment and its clinical burdens and whenever required, the Courts can supervise the process. But these procedures can verify the provided evidence, they cannot create preferences that the patient has not expressly stated.

Therefore, this case leaves a narrow but important boundary unresolved: when does reconstructing a patient's autonomy become attributing autonomy to the patient? The judgment takes reasonable steps to structure the decision, but does not clarify where this boundary lies. The deeper difficulty is not about who will speak on behalf of the patient but how the decision-maker can determine whether the voice being reconstructed is actually the patient's.

CONCLUSION

The case brings out a difficulty that becomes visible only when autonomy is reconstructed rather than exercised independently. Once the patient can no longer communicate, the law is not limited to identifying who can make the decision, it must determine whether the decision taken can be treated as the patient's own. The judgment places substituted judgment within the broader best-interest inquiry, but does not clarify the boundary between a patient's actual wishes and inferring those wishes from their circumstances and relationships. That boundary matters because following the procedure may make the decision legally valid, but it does not necessarily mean that the inference made about a patient's wishes is also certain. The key difficulty is not about who will speak on behalf of the patient, but how far the law can treat another person's reconstruction as the patient's own voice.