DOI: 10.21088/ijlhb.2454.7107.12126.5

Indian Journal of Law and Human Behavior
Volume 12 Number 1 / January - June 2026

REVIEW ARTICLE

Letting Nature Take its Course: The Supreme Court's Harish Rana Judgment and the Constitutional Architecture of Passive Euthanasia in India

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HOW TO CITE THIS ARTICLE:

Vivekanshu Verma, Shri Gopal Kabra, Promod Kumar Kohli. Letting Nature Take its Course: The Supreme Court's Harish Rana Judgment and the Constitutional Architecture of Passive Euthanasia in India. Indian J Law Hum Behav 2026; 12(1): 53-60.

ABSTRACT

Background: In 2026, the Supreme Court of India in Harish Rana v Union of India & Ors (2026 INSC 222) applied and substantially elaborated the passive euthanasia framework laid down in Common Cause (2018, 2023), in the concrete setting of a young man in a permanent vegetative state (PVS) maintained on Clinically Assisted Nutrition and Hydration (CANH) via PEG tube at home.

Objective: To critically analyse the medicolegal reasoning in Harish Rana, with specific focus on: (i) Classification of CANH as "medical treatment"; (ii) Refinement of the "best interest" test; and (iii) Operationalisation and streamlining of the Common Cause guidelines, including implications for clinicians, hospitals and families.

Methods: Doctrinal review of the full judgment text, read against prior Indian precedents (Aruna Shanbaug, Common Cause 2018, Common Cause 2023) and comparative jurisprudence from the UK, USA, EU and other jurisdictions expressly relied upon by the Court; thematic extraction of key medicolegal concepts (dignity, autonomy, authorised omission, futility, best interests) and their application to endoflife decisionmaking.

Key findings: The Court held that CANH delivered through PEG constitutes "medical treatment" and its withdrawal, when medically futile and not in the patient's best interests, falls within constitutionally permissible passive euthanasia rather than unlawful killing. It reaffirmed that Article 21's right to live with dignity includes a right to die with dignity in cases of terminal illness

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➢ **Received:** 12-03-2026 ➢ **Accepted:** 30-03-2026

or PVS where the process of natural death has commenced, and clarified that passive euthanasia is an "authorised omission" consistent with the physician's duty of care. Drawing on UK and US case law (Airedale, Cruzan, Aintree, WvM and others), it adopted a nuanced "***best interest***" framework integrating medical futility, absence of any realistic prospect of meaningful recovery, and nonmedical factors such as prior wishes, family perspectives and dignity. The judgment also identified gaps in implementation of Common Cause guidelines, particularly for longterm homebased patients, and issued detailed directions for boards, CMOs and governments to create clearer, safer pathways for withdrawal/withholding of treatment and provision of palliative care.

Conclusions: Harish Rana operationalises the abstract principles of Common Cause into a practically usable medicolegal template for withdrawing CANH in PVS, while robustly protecting dignity, autonomy and professional security. For treating doctors and forensic experts, it provides authoritative guidance on classifying CANH, documenting futility, engaging families, and navigating liability risks when discontinuing lifesustaining treatment.

KEYWORDS

• Passive euthanasia • Clinically Assisted Nutrition and Hydration (CANH) • PEG tube • Permanent vegetative state (PVS) • Best interests • Right to die with dignity • Article 21 • Common Cause guidelines • Endoflife care • Medical futility

INTRODUCTION

The Supreme Court's decision in Harish Rana v Union of India & Ors (Misc. Appl. No. 2238 of 2025 in SLP (C) 18225/2024; 2026 INSC 222) represents the first major application of the Common Cause passive euthanasia framework to a concrete, intensely factsensitive dispute over withdrawal of CANH in a young patient in PVS receiving homebased care.[1] The applicant, a 32 year old B.Tech student who had sustained diffuse axonal injury after a fall in 2013, had remained in a permanent vegetative state for over 13 years, dependent on tracheostomy, urinary catheterisation and PEGbased CANH, with 100% permanent disability duly certified by government hospitals.[2]

After the Delhi High Court refused to trigger the Common Cause mechanism on the ground that the patient was "not being kept alive mechanically", the parents approached the Supreme Court, which restored the medicalboard based process, constituted primary and secondary boards, and ultimately had to decide whether continued CANH via PEG was in the patient's "best interests". The Court used this case to (i) reaffirm and deepen the conceptual distinction between active and passive euthanasia, (ii) clearly classify CANH as "medical treatment", and (iii) refine the bestinterest and procedural safeguards in a way directly relevant to treating doctors, hospitals, and medicolegal experts.

For forensic and medicolegal practitioners, Harish Rana thus functions both as a doctrinal authority and as a practical checklist for endoflife decisionmaking, particularly where longterm, homebased patients on artificial nutrition and hydration are concerned.

Comparative table: Harish Rana and key passive euthanasia precedents

Aspect	Harish Rana v UOI (SC, 2026)3	Common Cause 2018 & 2023 (SC, India) 4,5	Aruna Shanbaug (SC, 2011)6	Airedale NHS Trust v Bland (HL, UK)7	Cruzan v Director, Missouri (US SC)8	Aintree9 & later UK COP10 cases
Patient condition	Young adult, posttraumatic diffuse axonal injury, 13 years in PVS, 100% permanent disability, cared mostly at home.	Hypothetical and general; addressed both competent and incompetent patients, AMDs, terminal illness and PVS.	Nurse in PVS after assault, institutionalised for decades.	Young man in PVS after disaster at football stadium, institutional care.	Young woman in PVS after RTA; longterm institutional care with CANH.	Mixed: chronic critical illness, limited consciousness, varying awareness levels.

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Treatment at issue	CANH via PEG tube, tracheostomy, homebased care; question whether CANH is "**medical treatment**" and may be withdrawn.	General category of "lifesustaining treatment", including ventilators and feeding tubes; laid down guidelines for withdrawal/ withholding.	Ventilatory and other lifesupport; Court cautiously allowed passive euthanasia only under HC supervision.	Artificial nutrition and hydration via nasogastric tube.	CANH, with parents seeking withdrawal.	Range of lifesustaining treatments (ventilation, CANH, etc.) in ICU and longterm care.
Classification of CANH	Explicitly affirms CANH via PEG as "**medical treatment**", not mere basic care; its withdrawal falls within passive euthanasia when futile and not in best interests.	Endorses Airedale's view that nasogastric feeding is medical treatment; notes feeding tubes as life support in concurring opinions.	Discussed feeding and life support but left classification relatively underdeveloped.	Holds nasogastric feeding to be medical treatment whose withdrawal is an omission, not active killing.	Treats CANH as lifesustaining treatment whose withdrawal requires clear and convincing evidence of patient's wishes.	Treats CANH as treatment assessed under Mental Capacity Act "best interest" test; routine court approval no longer mandatory in straightforward cases.
Euthanasia typology	Reexplains active vs passive euthanasia: active introduces a new lethal agency ("causing death"), passive is an omission that allows underlying condition to resume its natural course ("letting die").	Recognises only passive euthanasia as constitutionally permissible, grounded in authorised omission and duty of care; active euthanasia remains impermissible.	First Indian case to cautiously open door to passive euthanasia in PVS under strict safeguards.	Distinguishes withdrawal of treatment (omission allowing existing causes to operate) from active killing (external agency of death).	Accepts liberty interest in refusing treatment but upholds state's right to demand clear and convincing evidence; does not license active euthanasia.	Frames decisions as bestinterest treatment choices rather than "euthanasia"; emphasises distinction between acts that cause death and omissions that allow death.
Constitutional / rights basis	Applies Article 21: right to live with dignity includes right to die with dignity in terminal/ PVS states when natural death process has commenced; emphasises dignity, autonomy, privacy, and bodily integrity including for unconscious patients.	Declares right to die with dignity implicit in Article 21; recognises AMDs, passive euthanasia, and detailed guidelines as law until legislation.	Relies on Gian Kaur to cautiously endorse passive euthanasia; seeds concept of "right to die with dignity" in limited circumstances.	Analyses duty of care and law of omissions; grounded in commonlaw principles rather than a written constitution.	Anchors analysis in Due Process Clause and liberty interest in refusing unwanted medical treatment.	Applies statutory "best interests" test under **Mental Capacity Act 2005**, read consistently with ECHR rights (Article 2, 3, 8).
Best interest test	Develops a structured, twotiered bestinterest framework: (i) medical considerations (futility, no realistic prospect of meaningful recovery, prolonged and burdensome interventions); (ii) nonmedical considerations (dignity, prior wishes, values, family perspectives), drawing heavily on Aintree and later UK CoP decisions.	Mentions "**best interest**" and requires medical boards to consider futility, cure, and dignity, but leaves detailed structure largely for future elaboration.	Uses a more paternalistic, institutioncentric view, relying heavily on hospital and HC.	Accepts that treatment can be lawfully withdrawn when not in best interests of permanently insensate patient who cannot benefit from it.	Demands "**clear and convincing evidence**" of patient's wishes; largely stateinterest oriented, criticised in dissents for undervaluing autonomy and best interests.	Articulates nuanced, patientcentred bestinterest test: benefits vs burdens, view of life that the patient would find worthwhile, family life, emotional welfare, dignity.

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Role of family / surrogate	Treats parents and siblings as primary caregivers and crucial conveyors of patient's values; requires their informed, written participation at the board stage while warning that their decision must reflect patient's best interests, not their own burdens.	Incorporates next of kin / next friend / guardian consent as a formal step before board certification, especially where no AMD exists.	Vests substantial weight in hospital staff as "**next friend**" in institutional context.	Accepts family views but does not presume they always reflect patient's wishes; ultimate decision is legal/medical.	Majority refuses to presume that close family necessarily represent patient's wishes; insists on clear and convincing proof, while dissents criticise this as unrealistic.	Grants significant, but not decisive, weight to family accounts of patient's prior wishes and subjective values under s.4(6) MCA.
Procedural safeguards	Dualboard model (primary under CMO; secondary at AIIMS or equivalent) strictly applied; Court uses case to "**streamline and contextualise**" Common Cause guidelines with clarifications on: homecare patients, nomination of RMPs by CMOs, reconsideration period, and limited court intervention when process works properly.	Prescribes detailed, multilayered procedure for AMDs and nonAMD cases; 2023 modifications simplify and make guidelines more workable while retaining safeguards.	Required HC approval in each case; later effectively superseded by Common Cause.	No requirement for routine court approval once legal principle settled, though initial case was litigated.	Recognises state's power to shape procedures; no standardised medicalboard model.	Initially required court applications in PVS CANH withdrawal; later jurisprudence moves towards no mandatory court involvement if consensus and clear bestinterests.
Implementation & systemic directions	Highlights serious implementation deficits: lack of translation of guidelines into hospital practice, reliance on "Discharge Against Medical Advice" (DAMA), confusion among doctors; directs governments to (i) nominate AMD custodians, (ii) ensure constitution of primary/ secondary boards, (iii) empower CMOs to nominate RMPs, and (iv) ensure palliative and EOL care when CANH is withdrawn.	Declares guidelines as law of the land until legislation; notes need for state action but without detailed, casebased directions.	Mostly casespecific; later overtaken by Common Cause.	Systemic effect largely through professional and judicial adoption.	Influences state statutes and hospital policies; no centrally mandated medicalboard model.	Drives development of UK practice on when court applications are or aren't needed, and on the content of bestinterest assessments.

DISCUSSION

1. Facts, clinical trajectory and medicolegal context

Harish Rana had been in a persistent vegetative state since 2013 after a fall from a fourthfloor paying guest accommodation causing severe diffuse axonal injury, requiring initial management at a local hospital and then at PGI Chandigarh with ventilatory support, tracheostomy and nasogastric feeding before conversion to a PEG tube for longterm CANH. Over the subsequent 13 years, he remained bedridden with tracheostomy, catheterisation, PEGbased feeding, recurrent infections, bedsores, and complete sensorimotor dysfunction, with disability certificates from Janakpuri Super Speciality Hospital and Dr

Ram Manohar Lohia Hospital certifying 100% permanent disability and PVS.

By the time of the Miscellaneous Application, primary and secondary medical boards (including neurologists, neurosurgeons, anaesthesiologists, plastic surgeons and psychiatrists) independently concluded that he had nonprogressive, irreversible brain damage, fulfilled criteria for permanent PVS, had negligible chances of recovery, and that CANH was required only for bare survival without any realistic prospect of neurological improvement. The family, after prolonged caregiving and extensive unsuccessful treatments, expressed a clear, considered wish that futile lifeprolonging treatment be discontinued in the applicant's best interests, also voicing concerns about their own ageing and the absence of any meaningful life for him.

This factual matrix gave the Court a paradigmatic "hard case" in which to test the Common Cause architecture: a young, cognitively destroyed patient, objectively irreversible PVS, medically futile treatment, and a caring family asking the Court to "let nature take its own course".

2. Active versus passive euthanasia: authorised omission and causation

The judgment devotes substantial analysis to revisiting the distinction between active and passive euthanasia, explicitly warning against the simplistic "act versus omission" dichotomy that can misclassify mechanical steps like switching off ventilators or removing feeding tubes as active killing. Drawing from Common Cause 2018 and Airedale, the Court clarifies that the crux lies not in muscle movement but in causation: active euthanasia "causes" death by introducing a new external lethal agency, whereas passive euthanasia "allows" death to occur by withdrawing or withholding treatment so that the underlying disease resumes its natural course.

This "***causing death vs letting die***" framework is paired with the concept of "*authorised omission*" in consonance with the duty of care, meaning that withdrawal is lawful only where treatment is futile, burdensome, and no longer in the patient's best interests, and where the doctor's primary obligation to relieve suffering and respect dignity is thereby advanced. For medicolegal practice, this refined account of causation and omission is critical: it underpins the Court's finding that removing PEGbased CANH is not homicide or abetment of suicide, but a constitutionally protected form of passive euthanasia when properly indicated and procedurally safeguarded.

3. CANH as "medical treatment" and its implications

A central medicolegal issue was whether CANH administered through PEG qualifies as "medical treatment" or only as basic care (like ordinary feeding), since only the former falls within the Common Cause withdrawal/ withholding framework. The Court, aligning firmly with Airedale and the reasoning in Common Cause, holds that devicedelivered CANH is a lifesustaining medical intervention and not mere basic care, because it is invasive, technologically mediated, and maintained by medical professionals in the context of severe neurodisability.

By explicitly categorising CANH via PEG as treatment, the Court removes a major source of confusion that had led the Delhi High Court to previously refuse intervention on the ground that the applicant was "not being kept alive mechanically". For clinicians and forensic experts, this classification has direct liability consequences: withdrawal of PEGbased CANH in appropriate circumstances falls squarely within the passive euthanasia framework, whereas arbitrary or unilateral withdrawal outside the Common Cause/Harish Rana procedures may still attract criminal or civil accountability.

4. Best interest: integrating medical futility, dignity and patientcentred values

Harish Rana significantly deepens the "***best interest of the patient***" analysis beyond the bare references in Common Cause by extensively drawing on UK jurisprudence, especially Aintree, W v M, and subsequent Court of Protection (COP) decisions. It distinguishes:

- **Medical considerations**:
  - Futility to be understood not merely as "**incurable disease**" but as treatment that is ineffective, useless or confers no benefit to that particular patient, especially when prolonged over time despite exhausting reasonable therapeutic options.
  - Recovery not as restoration to full health but as resumption of a quality

of life that the patient would regard as worthwhile.

- Necessity to consider the burdens (pain, invasiveness, infections, bedsores, dependence on artificial devices) versus any benefits of continued treatment.

- **Nonmedical considerations**:
- Dignity as a central, normative value: prolonging a purely vegetative, insensate existence with painful complications may actively undermine dignity rather than honour it.
- Patient's own past wishes, values and lifestyle (inferred from testimony about his energetic, physically active life, interest in sports and gymming) as indicative of what he would likely have considered an acceptable quality of life.
- Family's perceptions and emotional accounts, treated as important but not decisive in themselves; they must reflect the patient's best interests, not caregiver fatigue or external pressures.

This composite test leads the Court to ask not whether it is in the patient's best interests to die, but whether it is in his best interests that his life be artificially prolonged through CANH in circumstances of irreversible PVS and total dependence. On the evidence, the Court concludes that continued CANH serves no therapeutic or rehabilitative purpose, imposes significant burden and indignity, and therefore is not in his best interests; consequently, its withdrawal is justified.

5. Autonomy, dignity and the right to die with dignity under Article 21

Building on Gian Kaur,[11] and Common Cause,[12] the Court reiterates that Article 21's guarantee of life is not confined to mere biological survival but encompasses the right to live with dignity "up to the end of natural life", including a dignified process of dying when death is certain and imminent. It carefully distinguishes between (i) an impermissible absolute "***right to die***" (suicide, premature curtailment of life) and (ii) a limited right to die with dignity where the process of natural death has already commenced (terminal illness, irreversible PVS) and continued intervention only postpones the inevitable at the cost of prolonged suffering and indignity.

Within this framework, passive euthanasia is conceptualised as constitutionally protected because it accelerates the end of an already ongoing natural dying process relative to artificial prolongation, without truncating the natural span of life by introducing a new lethal cause. For incompetent patients in PVS, the Court emphasises bodily integrity and selfdetermination through substituted decisionmaking: family members and medical boards must strive to reconstruct what the patient would have chosen, rather than impose their own preferences, echoing both Aruna Shanbaug,[13] and comparative authorities like Cruzan,[14] and Aintree.[15]

6. Procedural architecture: boards, CMOs, courts and homebased care

Procedurally, the case showcases the full operation of the Common Cause model:

- A primary medical board constituted under the CMO, Ghaziabad, visiting the applicant at home and opining that he was in irreversible PVS with negligible chances of recovery.
- A secondary medical board at AIIMS, New Delhi, providing a detailed clinical and neurological evaluation, confirming permanent PVS, irreversible brain damage, and futility of CANH in terms of neurological improvement.
- Structured dialogues between counsel, boards, Ministry of Health & Family Welfare officials and the family, culminating in clear documentation of consensus that continuation of CANH constituted futile, burdensome treatment not in the applicant's best interests.

The Court uses this experience to identify procedural gaps, especially for longterm homebased patients who are not under active hospital care and therefore cannot trigger the usual hospitalbased primary board mechanism envisaged in Common Cause. It therefore issues clarifications and directions on:

- CMO's responsibility to constitute primary boards and nominate registered medical practitioners to secondary boards.
- Creation of mechanisms for patients receiving treatment at home to access the board process.

- The limited, supervisory role of High Courts and the Supreme Court, intended only when medical boards disagree or the process reaches an impasse, not for routine adjudication of every case.
- Ensuring palliative and endoflife care at home or in a hospital of the family's choosing during and after withdrawal of CANH, so that the patient's last phase is characterised by comfort and dignity rather than abandonment.

For hospitals and practitioners, these clarifications convert an abstract set of guidelines into a more operational protocol, reducing fears of criminal liability and encouraging ethically sound endoflife decisions.

7. Implementation challenges and medicolegal risk management

The Court expressly acknowledges that Common Cause guidelines have not been effectively translated into clinical practice across India, leading to widespread confusion among doctors and administrators about their obligations, and to problematic practices such as routine discharge "**Against Medical Advice**" without adequate palliative care. It accepts counsel's concern that the absence of clear institutional mechanisms dis-incentivises candid discussions about futility, prolongs unnecessary treatment, and exposes both patients and doctors to avoidable suffering and medicolegal risk.

From a riskmanagement perspective, Harish Rana suggests the following practical imperatives for clinicians and forensic/medicolegal professionals:

- Treat devicemediated CANH (PEG, NG tubes, parenteral nutrition) as medical treatment subject to Common Cause and Harish Rana standards; document this classification and rationale.
- Initiate formal futility and bestinterest assessments when treatment appears only to prolong dying without meaningful benefit, ensuring multidisciplinary input and adherence to board procedures.
- Engagefamiliesearlyandcompassionately, explaining the medical realities, expected trajectory, and legal framework, while recording their views, concerns and any recollected patient wishes.
- Avoid "**defensive**" discharges that leave families unsupported; instead, integrate palliative care and symptom control, whether or not lifesustaining treatment is withdrawn.
- Maintain meticulous records of clinical findings, diagnostic criteria for PVS, board deliberations, consent, and implementation steps, to demonstrate compliance with constitutional and professional standards in any later inquiry or litigation.

CONCLUSION

The Harish Rana judgment marks a watershed in Indian endoflife jurisprudence by transforming the theoretical contours of Common Cause into a workable, clinically grounded framework for withdrawing CANH in permanent vegetative states, particularly in longterm homecare settings. It clarifies the status of CANH as medical treatment, refines the active/passive euthanasia distinction through the lens of causation and authorised omission, and elaborates a sophisticated bestinterest test that integrates medical futility, dignity, and inferred patient values.

For medicolegal practitioners, forensic experts and treating clinicians, the decision provides both a shield and a roadmap: a shield against criminalisation when they withdraw futile lifesustaining treatment in accordance with boards and guidelines, and a roadmap for documentation, communication and ethical decisionmaking that honours the patient's right to die with dignity under Article 21. At the same time, it underscores the urgent need for legislative action and robust institutionalisation of palliative and endoflife care so that courts remain fora of last resort rather than de facto gatekeepers for every difficult decision at the bedside.

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