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THE RIGHT TO DIE WITH DIGNITY IN INDIA: EXAMINING THE HARISH RANA JUDGEMENT AND THE IMPERATIVE OF END-OF-LIFE LEGISLATION

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ABSTRACT

On 11th March 2026, the Supreme Court of India, for the first time, gave practical effect to the passive euthanasia guidelines it had laid down in *Common Cause vs. Union of India* (2018)[1], translating nearly eight years of constitutional promise into clinical reality in the case of *Harish Rana vs. Union of India*[2], decided by the Bench of Justices J.B. Pardiwala and K.V. Viswanathan. In doing so, the Court moved the 2018 *Common Cause* guidelines from theory to practice for the very first time in Indian legal history. The judgment makes three foundational doctrinal contributions: the reclassification of Clinically Assisted Nutrition and Hydration (CANH) as a *medical treatment* rather than basic nursing care, the elaboration of the *best interests standard* grounded in the substituted judgment approach, and the mandatory link between treatment withdrawal and a structured palliative care plan. Together, these contributions resolve the classification impasse that caused the Delhi High Court to deny relief in 2024, and expose the continuing constitutional insufficiency of judge-made guidelines governing such a profound domain of human dignity. This article traces the jurisprudential arc from *P. Rathinam (1994)*[3] to *Harish Rana (2026)* and argues that India's reliance on judicial improvisation, however courageous, remains ethically precarious, practically unjust, and structurally fragile. The Court has itself described this framework as 'fragile', and its renewed, urgent call to Parliament must not be answered with further silence. Thus, dying with dignity should not remain a remedy only available to those who can afford to legislate for it.

Keywords: *right to die with dignity; CANH; end-of-life legislation; Harish Rana vs. Union of India; end-of-life care.*

INTRODUCTION: WHEN CONSTITUTIONAL PROMISE MEETS THE HUMAN BEING

"The right to die with dignity is not the right to die but the right to live with dignity until the last breath."- Justice D.Y. Chandrachud.[4]

Every constitutional promise has a moment of reckoning, a point where abstract principle must answer to the concrete suffering. For India's right to die with dignity, that moment occurred in March 2026, in the case of a young man from Ghaziabad who had not opened his eyes with awareness since 2013. In August 2013, Harish Rana, a 19-year-old student in Chandigarh, fell from a fourth-floor balcony and sustained a severe brain injury. Since then, for a period of thirteen years, he lay in a Persistent Vegetative State (PVS), sustained solely by Clinically Assisted Nutrition and Hydration (CANH) administered through surgically implanted PEG tubes. He was reduced to a state where he could neither communicate nor recover; thus, his parents, watching helplessly, sought legal relief—the right to let him rest.[5]

Article 21[6] of the Indian Constitution has long been read expansively to encompass various rights, including privacy, health, livelihood, and, by 2018, dignity in dying. In 2018, this Article was in question, wherein it was observed that the Right to die with Dignity is an inseparable facet of the Right to Life, and

[1] *Common Cause (A Regd. Soc'y) vs. Union of India,* (2018) 5 S.C.C. 1.
[2] *Harish Rana vs. Union of India,* 2026 INSC 222.
[3] *P. Rathinam vs. Union of India,* (1994) 3 S.C.C. 394.
[4] *Common Cause, supra* note 2.
[5] *Harish Rana, supra* note 1.
[6] India Const. art. 21.

further distinguished between the two concepts of Active Euthanasia and Passive Euthanasia with the elaborate procedural guidelines for the latter. Despite this legal breakthrough, the 2018 guidelines were so procedurally dense that they functioned more as a barrier than a bridge; not a single family exercised this right for nearly eight years and relied on the term 'pious hope' that Parliament would legislate on the subject.[7] That hope remained unfulfilled until the case of *Harish Rana* arrived.

The judgment is remarkable not merely for what it decided but for what it revealed. It revealed that a right solemnly recognized by the Constitutional Bench in 2018, the right to die with dignity as an inseparable dimension of Article 21, just remained a right on paper for about eight years, thus accessible only in theory to all, but in practice only to the families with legal literacy, financial endurance, and geographic proximity to navigate the procedurally forbidding judicial process. This itself is a central indictment of this paper.

Harish Rana's case is thus the first where India's passive euthanasia framework has been put into practice and not just kept as theory, and it corrects a specific doctrinal error and streamlines specific guidelines, but it cannot, by itself, cure the structural failure that produced such error. This development was thus a result of judicial action rather than a legislative framework calling for Parliament's action.

THE JURISPRUDENTIAL ARC: TRACING INDIA'S RIGHT-TO-DIE DOCTRINE

The Early Hesitations: P. Rathinam and Gian Kaur

The legal history of the right to die in India has always remained in controversy, and it began with the provision about living. The case of *P. Rathinam vs. Union of India* (1994) was the case where the Supreme Court of India held that Section 309 of the Indian Penal Code, which criminalized attempts to commit suicide, was unconstitutional, as the right to life under Article 21 does not necessarily encompass a right not to live.[8] However, later, in *Gian Kaur vs. State of Punjab* (1996), a five-judge constitutional bench overruled the *Rathinam* decision and held that the right to life does not include the right to die and that Section 309 IPC was constitutionally valid.[9] However, the court in this case preserved the possibility of passive euthanasia, noting that the right to die with dignity at the end of life is different from the criminalized right to extinguish life.

This careful differentiation between the right to an artificially prolonged physical existence and the right to a natural death with dignity laid the groundwork that would eventually bloom in Aruna Shanbaug and Common Cause.

Aruna Shanbaug vs. Union of India Case: The First Threshold

The case of *Aruna Shanbaug* arose from one of India's most prolonged and publicized episodes of medical tragedy. Here, a two-judge bench of the Supreme Court faced a tragic case of the nurse who had been in a vegetative state for about 38 years after a brutal assault; this laid the first formal constitutional ground for passive euthanasia in India.[10] The Court, while allowing withdrawal of Aruna's life support, took care of specific facts, ensured that hospital staff take proper care of her, and legalized passive euthanasia as a concept and established the procedural safeguards, including the requirement of the High Court's approval for the withdrawal of treatment in the absence of a living will. The court, however, rejected active euthanasia by lethal injection. The court thus distinguished between active euthanasia and passive euthanasia, allowing death to occur naturally from the underlying condition.

[7] *Common Cause, supra* note 2, at para 196 (Chandrachud, J.).
[8] *P. Rathinam, supra* note 3.
[9] *Gian Kaur vs. State of Punjab,* (1996) 2 S.C.C. 454.
[10] *Aruna Ramachandra Shanbaug vs. Union of India,* (2011) 4 S.C.C. 454.

Thus, this case was a pivotal step, but it left the right floating without a statutory base. The guidelines it laid were judicially improvised and were made applicable through a procedure of prior approval from the High Court in each case under Article 226, following an examination by a panel of medical experts. This contribution was procedurally cumbersome and practically inaccessible for the majority of Indian families.

Common Cause vs. Union of India: The Constitutional Foundation

The definitive jurisprudential moment arrived in the *Common Cause* case, where the Bench issued a judgment that represented a generational shift in India's approach to end-of-life rights. The Court for the first time recognized with full constitutional force the right to die with dignity as an inherent and inseparable dimension of the right to life under Article 21.[11] The court observed that passive euthanasia, that is, the withdrawal of life-sustaining medical treatment, is constitutionally permissible and also validated the concept of an Advance Medical Directive (AMD) or 'living will' through which a competent individual can prospectively authorize treatment withdrawal in the event of irreversible medical incapacity.

The Court also expressed what it termed as 'pious hope' and simultaneously pointed an institutional expectation that Parliament would intervene and enact appropriate legislation governing end-of-life decisions, noting the grave inadequacy of having such fundamental questions governed only by judicially crafted guidelines. The guidelines required primary and secondary medical boards, magistrate notifications, and High Court oversight for governing the process until such legislation is materialized. In January 2023, the court simplified these guidelines, removing the requirement that a Judicial Magistrate countersign the living will and streamlining the medical board constitution.[12]

Yet, after so many years, the Parliament has not made any enactment respecting the same. The Ministry of Health and Family Welfare released a Draft Medical Treatment of Terminally-ill Patients (Protection of Patients and Medical Practitioners) Bill in 2016, which never came into enactment beyond the consultation stage. Even the Directorate General of Health Services released draft guidelines for withdrawal of life support in 2024 for public consultation, which also reached no conclusion.[13] And in this legislative vacuum, the Harish Rana case arrived.

HARISH RANA CASE: DOCTRINAL CONTRIBUTIONS MADE

CANH as Medical Treatment: Resolving the Classification Dispute

The most significant doctrinal contribution of the Harish Rana judgment is its decisive resolution of a question that paralyzed Indian courts, specifically causing the Delhi High Court to deny the family's plea in 2024. The question was whether Clinically Assisted Nutrition and Hydration (CANH) constitutes 'medical treatment' subject to the passive euthanasia framework or merely 'basic nursing care' that will continue despite the patient's prognosis.

Harish Rana was not on a mechanical ventilator. His continued existence depended entirely on nutrition and hydration delivered through a surgically implanted PEG tube. The Delhi High Court reasoned that as he was not on mechanical ventilation, he did not fall within the criteria of the 'terminally ill' threshold under prior interpretations of the Common Cause guidelines. More critically, it held that withdrawal of the feeding tube would not amount to

[11] *Common Cause, supra* note 2.
[12] *Id.*
[13] Ministry of Health and Family Welfare, Draft Medical Treatment of Terminally Ill Patients (Protection of Patients and Medical Practitioners) Bill (2016) (India).

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passive euthanasia but an active intervention causing death.[14] This was an erroneous reading, which the Supreme Court corrected.

The Bench held that CANH, whether delivered through a nasogastric tube or surgically implanted PEG device, constitutes medical treatment and not basic nursing care.[15] The court's reasoning was clinically grounded and held that the prescription and the administration of CANH involve careful consideration of a multitude factors, including the installation of the CANH device, assessment of the patient's nutritional requirements, gastrointestinal tolerance, metabolic stability, and potential complications, requiring active medical judgment and management.[16] This very much falls within the permissible scope of passive euthanasia: a situation where life-sustaining treatment may be withdrawn when its continuation serves no therapeutic purpose and merely prolongs an undignified existence.

This ruling aligns Indian law with the settled jurisprudence of the U.K., as witnessed in *Airedale NHS Trust vs. Bland,*[17] where withdrawal of artificial nutrition from a patient in a persistent vegetative state was permitted as passive rather than active euthanasia. The European Convention on Human Rights by permitting withdrawal of artificial nutrition from a patient in an irreversible vegetative state.[18] The Supreme Court's comparative engagement with varieties of UK decisions demonstrates the global convergence on this point that India's courts had hitherto navigated with hesitation.

The Best Interests Standard: Giving Dignity an Operational Content

The second major contribution of the Harish Rana decision is its elaboration of the 'best interests of the patient' standard as the governing legal test for withdrawal of life-sustaining treatment in cases of non-voluntary passive euthanasia, the cases where the patient lacks the capacity to express contemporaneous consent.

The court identified two grounds that should be met before any decision regarding withdrawal or withholding of medical treatment is addressed. First, the intervention must qualify as 'medical treatment'; and second, its withdrawal must strictly be in the 'best interest' of the patient. In determining 'best interests,' the court directed consideration of several factors that are by now well-established in comparative jurisprudence: medical futility (whether continued treatment serves any therapeutic purpose), irreversibility of the patient's condition, the concept of dignity (whether continued existence reflects a dignified life in the constitutional sense), and the views of the patient's family and the recommendations of the medical boards constituted under the Common Cause guidelines.[19]

This approach resembles the framework established under Section 4 of the U.K.'s Mental Capacity Act 2005, which codifies a comprehensive best interests checklist for decisions made on behalf of incapacitated individuals. As also noted by Boyle in *the International Journal of Mental Health and Capacity Law,* ' any decision about life-sustaining treatment for a person lacking capacity will take as its starting point the assumption that it is in the person's best interest for life to continue,' but such presumption is rebuttable where continued treatment is clinically

[14] *Petition of the Father of Harish Rana vs. Union of India,* W.P. (Civ.) (Del. H.C. 2024)(unreported).
[15] *Harish Rana, supra* note 1.
[16] *Id.*(analysis of CANH as medical treatment, citing: prescription and administration of CANH requires clinical assessment of device installation, nutritional requirements, gastrointestinal tolerance, metabolic stability and potential complications).
[17] *Airedale NHS Trust v. Bland*, [1993] AC 789 (HL) (Eng.).
[18] *Lambert v. France*, 2015-II Eur. Ct. H.R. 1.
[19] *Harish Rana, supra* note 1, paras 84–92.

futile.[20] The Medical Law Review has similarly observed that the best interests standard, properly applied, must integrate clinical judgment with the patient's prior wishes, values, and the assessment of a multidisciplinary team, rather than being reduced to a purely medical calculus.[21]

Applying this analysis to Harish Rana, whose continued existence was sustained artificially without any neurological function and whose family sought withdrawal, the court observed that continued use of the life-supporting system served no medical purpose and merely prolonged an undignified existence without any prospect of recovery. Thus, the court authorized the withdrawal under a robust palliative and end-of-life care plan at AIIMS New Delhi, wherein the family was permitted to make a choice between institutional and home-based palliative care. Following the Court's order and the withdrawal of CANH, Harish Rana passed away on March 24, 2026, bringing to close thirteen years of profound suffering. His death, peaceful and attended by his family, shows the first instance in Indian legal history where the right to die with dignity moved from judicial recognition to clinical practice.

The articulation of the best interests standard is significant, as it provides for the first time structured analytical framework for clinicians and courts to follow when a patient cannot direct their care. It transforms what had been an amorphous constitutional value ('dignity') into an operational legal standard with identifiable criteria. At the same time, the judgment is candid that the court had to waive the mandatory 30-day consideration period prescribed by the Common Cause guidelines in the specific circumstances and the acknowledgment that even the streamlined 2023 guidelines remain too rigid for the clinical realities of families.[22]

The Call to the Parliament: Beyond 'Pious Hope'

The third and most vital aspect that Harish Case highlights is the urgent exhortation to Parliament. The Court realized and thus observed that the ' cumulative effect of prolonged legislative inaction is leaving citizens, particularly those situated at the most vulnerable threshold of life, exposed to serious and systemic risk.'[23] It recalled the Parliament's legislative competence under Entry 26 of the Concurrent List (List III), Schedule Seven of the Indian Constitution, which covers 'legal, medical, and other professions,' and Entry 1 of List III, covering 'criminal law' insofar as the provisions of the Bharatiya Nyaya Sanhita, 2023 (successor of the Indian Penal Code) dealing with suicide and culpable homicide intersect with end-of-life decisions.[24]

The court's understanding was restrained, as it could not direct Parliament to legislate. But it made a strategic move by cataloging, with clinical precision, the specific gaps the legislation must address and observed that a comprehensive statute would remove definitional ambiguity by distinguishing terminally ill patients from patients in a PVS, standardizing the constitution and procedures of medical boards, and resolving the ambiguity that led the Delhi High Court to deny Harish Rana's family relief in 2024. Thus, the progress from Common Causes's 'pious hope' to a now far more emphatic call reflects a delicate institutional balance, where an accumulated weight of eight years during which Indian Families confronted the full cost of parliamentary abdication.

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[20] J. Boyle, *Mental Capacity Act 2005: The Statutory Principles and the Best Interests Test*, 11 Journal of Mental Health L. 149, 158 (2005).

[21] R. Heywood, *R (Burke) v. GMC Revisited: Patient and Family Rights in End-of-Life Decision-Making,* 18 Med. L. Rev. 63, 71 (2010).

[22] *Harish Rana, supra* note 1, para 104.

[23] *Ibid.* para 119.

[24] India Const. art. 246, sched. VII, list III, entires 1, 26; *see* also *Bharatiya Nyaya Sanhita*, 2023, ss. 100-113 (dealing with culpable homicide and related offences) (India).

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THE LEGISLATIVE VACUUM: WHY JUDICIAL GUIDELINES ARE NOT ENOUGH

The Structural Insufficiency of Judge-Made Laws

The passive euthanasia framework in India consists of three major judicial developments: Aruna Shanbaug (2011), Common Cause (2018), and the 2023 modification order, which are supplemented by the Harish Rana case in 2026. This is constitutionally anomalous, as a decision carrying the most profound moral and ethical stakes provides a regime that determines when life-sustaining medical treatment may be withdrawn, and this cannot indefinitely rest upon ad hoc judicial guidelines susceptible to reinterpretation in every case.

Judge-made guidelines, however, carry certain limitations: they cannot anticipate every clinical situation; they cannot create the proper infrastructure, such as containing trained palliative care teams and standardized medical boards in district hospitals necessary to operationalize the right they recognize; they cannot establish criminal immunity for medical practitioners who act in good faith pursuant to the guidelines; and they cannot resolve the tensions between the guidelines and provisions of the BNS, 2023 on culpable homicide and abetment of suicide, which continues to cast a shadow of criminal liability on physicians involved in withdrawal decisions.[25] It is also observed that the absence of a legislative anchor for end-of-life decisions 'forces both clinicians and families into a state of perpetual legal uncertainty, where the exercise of a constitutional right becomes dependent on the outcome of expensive and time-consuming litigation.'[26]

The Access to Justice Deficit

Perhaps the most serious practical consequence of the legislative vacuum is the egregious access to justice deficiency that it perpetuates. The Supreme Court in Harish Rana explicitly acknowledged that 'financial distress should not shape end-of-life decisions.'[27] Yet, the current procedural formalities require the constitution of medical boards, notification to the Chief Medical Officer, a 30-day reconsideration period, and the possibility of judicial review before the High Court, is accessible only by the families with financial resources, legal literacy, and proximity to major urban centers. The family of Harish Rana spent years petitioning courts. Most families in analogous situations, in rural Uttar Pradesh, in tribal districts of Chattisgarh, and in the geographically remote Northeast, will never be able to access the Supreme Court at all.

Thus, the constitutional right to die with dignity is thus a right of the privileged. There is a need for properly framed legislation with accessible administrative procedures and district-level medical infrastructure; mandatory palliative infrastructure is the only way to properly democratize this right.

The Comparative Argument: What India Can Gain

India is not legislating in a vacuum. In the United Kingdom, the Mental Capacity Act 2005 provides a comprehensive statutory framework for treatment decisions in respect of incapacitated adults, establishing the 'best interests' standard in primary legislation with detailed procedural requirements, providing for Lasting Powers of Attorney and Advance Decisions to Refuse Treatment, and establishing the Court of Protection as a specialist forum for contested decisions.[28] As Brenda Hale (then

[25] Bharatiya Nyaya Sanhita, 2023, ss. 100-103 (on culpable homicide and abetment); Mental Healthcare Act, 2017, s. 115 (India).

[26] Sharmila Sreekumar, *Judicial Legislation and the Limits of Constitutional Adjudication in End-of-Life Care*, 14(1) J. Indian L. & Soc'y 45, 58 (2022).

[27] *Harish Rana, supra* note 1, para 112.

[28] Mental Capacity Act 2005, ss 1, 4, 24–26 (UK).

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Lady Hale of the UK Supreme Court) noted, the Act's fundamental purpose is to empower people to make their own decisions where they can and to protect them when they cannot, but to always act in their best interests.[29]

Australia enacted Voluntary Assisted Dying Legislation in all six states, along with Victoria's Voluntary Assisted Dying Act 2029, providing a model for procedural rigor and systematic safeguards.[30] Closer to India's socio-legal context, the New Zealand End of Life Choice Act 2019 demonstrates how a common-law jurisdiction with a diverse population and a strong public health infrastructure has legislated a right to assisted dying without abandoning meaningful safeguards.[31] These global frameworks cannot directly be transplanted within the Indian landscape. Its constitutional framework, religious diversity, socioeconomic conditions, and constrained public health infrastructure demand a legislative response that is homegrown rather than borrowed. These comparative experiences demonstrate that the task of legislating on this subject is neither impossible nor unprecedented; it requires political will and not legal creativity.

What a Comprehensive Indian Statute [illegible] Contain

Drawing from Harish Rana's and the comparative understanding surveyed above, it is indicated that India should carefully legislate end-of-life care with the following minimum elements.

First, there is a need of clear definitional architecture. The statute must define 'terminal illness,' 'persistent vegetative state,' 'Clinically Assisted Nutrition and Hydration,' 'Advance Medical Directive,' and 'best interests of the patient' with enough precision to avoid interpretive gaps that produced the 2024 ruling. The distinction between active euthanasia (which must remain impermissible) and the withdrawal or withholding of life-sustaining treatment (which is permissible under safeguards) must be codified in terms accessible to clinicians and not just only to lawyers.

Second, the medical boards need to be institutionalized. The statute should mandate district-level Primary Medical Boards with defined specialization requirements, timelines, and documentation standards. Secondary review boards should include representation from outside the treating hospital to prevent institutional bias. Their decisions should be subject to a defined appeals mechanism before High Courts, with timelines to prevent interminable delays that characterized the Harish Rana family's ordeal.

Third, the most urgent need is the need for criminal immunity for compliant practitioners. Physicians acting in good faith within the statutory framework must be expressly immunized from prosecution under the BNS, 2023, for culpable homicide or abetment. In the absence of such immunity, clinical decision-making will remain paralyzed, and the constitutional right to die with dignity will remain exercisable on paper alone.

Fourth, access to palliative care is to be made universal. The statute must place a positive obligation on the state to ensure that palliative care infrastructure, including trained personnel and essential medicines, is available at district hospitals. The National Programme for Palliative Care's Operational Guidelines (2027) provide a base[32]; legislation must convert such commitment to a statutory entitlement. As the Supreme Court recognized in the Harish Rana

[29] *R (Burke) v. General Medical Council,* [2005] EWCA (Civ) 1003, [2006] QB 273, per Baroness Hale (extra-judicial address, 2006) (Eng.).

[30] Voluntary Assisted Dying Act 2019 (Vic) pt. 4 (Austl.); Voluntary Assisted Dying Review Board, Annual Report 2022–23 (Austl.).

[31] End of Life Choice Act 2019, s 5 (eligibility criteria), s 9 (independent assessment) (N.Z.).

[32] Directorate General of Health Services, Ministry of Health and Family Welfare, Operational Guidelines for Palliative Care at Ayushman Arogya Mandir (Health and Wellness Centres) (2027) (India).

case, the choice to withdraw or withhold treatment cannot become a forfeiture of structured medical support.

Fifth, a need for a living will registry. A centralized, electronically accessible registry of Advance Medical Directives must be created, linked to Aadhar or an equivalent identifier, so that a patient's recorded wishes can be retrieved in emergency clinical settings. The 2023 modification of Common Cause attempted to simplify living will execution; a statutory registry would make those directives practically enforceable.

CONCLUSION: DIGNITY CANNOT WAIT FOR PARLIAMENT'S ACTION

Harish Rana's judgment is thus an act of judicial courage. It broke a doctrinal deadlock that had cost a family two additional years of litigation after ruling in 2024. It gave constitutional substance to the skeletal framework of Common Cause by articulating a structured best interests standard, one that clinicians can apply and courts can meaningfully review. It brought the Indian legal position into alignment with the settled jurisprudence of the United Kingdom and the ECHR on CANH. And it spoke to Parliament with an urgency and directness that years of 'pious hope' never quite achieved.

But judicial courage, however necessary, cannot substitute the legislative action. The Harish Rana family navigated thirteen years of medical tragedy, two rounds of litigation across two tiers of court, and a procedural labyrinth built for a different era before a court finally said yes. Most families in India will never have the opportunity. They will make end-of-life decisions in corridors of district hospitals and government-run wards, without legal counsel, without institutional support, and without the constitutional protection they are theoretically entitled to.

Therefore, the right to die with dignity is not a privilege only for those who can afford to legislate but is a constitutional guarantee extended, by the terms of Article 21 itself, to every person on Indian soil. A guarantee that cannot be exercised without approaching the Supreme Court is not a right; it is a mirage. India's Parliament has now been called upon, with increasing urgency, by a court that has done everything within its power short of legislating itself. The time for 'pious hope' has passed. What is now required is a statute, grounded in constitutional values, designed for clinical realities, and built to serve not just the families who can reach the Supreme Court, but the many more who cannot.

Thus, the Harish Rana will be remembered as the case where India's passive euthanasia framework moved, for the first time, from theory into practice. It should also be remembered as the last time Parliament needed to be told.

"Death is not the greatest loss in life. The greatest loss is what dies inside us while we live." – Norman Cousins

Every year Parliament looks away, somewhere in India a person lies on life support against their will, a family breaks under the weight of a decision the law refuses to make, and a constitutional promise fails. Harish Rana was not simply a difficult case, he was thus a mirror against the legislative failure. The suffering of Harish Rana thus ended not by parliamentary will but by judicial courage. His thirteen years were not unusual. Without a law, they are just a template.

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