DIGNITY OVER DURATION: SUPREME COURT PERMITS WITHDRAWAL OF TREATMENT IN LANDMARK PASSIVE EUTHANASIA RULING

Naman Dudhoria, Jindal Global Law School, O.P. Jindal Global University

ABSTRACT

On March 11, 2026, the Supreme Court of India authorised the withdrawal of life sustaining medical treatment from Harish Rana, a 32-year-old man who had remained in a Permanent Vegetative State for over thirteen years following a fall in 2013. The ruling, delivered by Justice Pardiwala, represents the most significant judicial development in Indian end-of-life law since the Constitutional Bench's landmark decision in *Common Cause v. Union of India,* (2018).

The judgement resolved two critical legal questions. First, it conclusively held that clinically assisted nutrition and hydration (CANH) delivered via a tube constitutes "medical treatment" and not mere sustenance, therefore subject to the same withdrawal framework governing other life-sustaining interventions. This aligns Indian law with the House of Lords position in *Airedale NHS Trust v. Bland*. Second, it articulated a holistic best interest standard for incompetent patients, combining medical futility assessment with a substituted judgement inquiry into what the patient himself would have wished.

The Court also modernised the procedural framework inherited from *Common Cause* 2018- It extended withdrawal guidelines to home-based care settings, directed the establishment of standing CMO panels to prevent administrative delays, and clarified that unanimous medical board findings render judicial intervention non-mandatory. The judgement reaffirms that active euthanasia remains constitutionally impermissible and exclusively within Parliament's legislative domain. It sharply criticises two decades of legislative inaction spanning Law Commission Reports No. 196 (2006) and No. 241 (2012) through *Common Cause* 2018 during which no statute has been enacted.

The decision marks a pivotal expansion of the constitutional right to die with dignity under Article 21, while exposing the urgent need for comprehensive parliamentary legislation governing end-of-life care in India.

A Life Frozen in Time

On August 20, 2013, Harish Rana, was a twenty-year-old B.Tech student at Punjab University, described as energetic, fond of football and video games, with his whole life ahead of him. Tragically that evening, he fell from the fourth floor of his paying guest accommodation in Garhwal, sustaining a diffuse axonal injury that would define the rest of his existence. Rushed first to a local hospital and then to the Postgraduate Institute of Medical Education and Research, Chandigarh, he was discharged a week later without meaningful recovery.

For the thirteen years that followed, Harish lay bedridden at his family home in Ghaziabad, sustained by a tracheostomy tube, a urinary catheter, and clinically assisted nutrition and hydration (CANH) delivered through a surgically installed Percutaneous Endoscopic Gastrostomy (PEG) tube replaced every two months. He showed no awareness of his environment with no response to sound, touch, or pain, and no ability to communicate. Multiple disability certificates from Janakpuri Super Speciality Hospital in 2014 and Dr. Ram Manohar Lohia Hospital in 2016 certified him as being in a Persistent Vegetative State (PVS) with 100 per cent permanent physical disability.

His parents and siblings provided round-the-clock care for over a decade. They tried every available treatment, including hyperbaric oxygen therapy. Nothing changed and with their own advancing age, his parents began to ask the question that the Indian legal system has itself been unresponsive to i.e. could they lawfully ask the doctors to stop?

Harish Rana's family first approached the Delhi High Court in 2024, filing a writ petition[1] seeking a determination on whether his medical treatment should be withdrawn in accordance with the framework laid down by the Supreme Court's Constitutional Bench in *Common Cause v. Union of India, (2018)*[2] (Common Cause 2018). The High Court dismissed the petition on July 2, 2024, with reasoning that Harish was not being kept alive mechanically and could sustain himself without extraordinary external aid and that no judicial intervention was therefore warranted.

The family challenged this before the Supreme Court via a Special Leave Petition[3]. On

[1] W.P.(C) No. 4927/2024 (H.C. Del.)
[2] 5 SCC 1
[3] S.L.P.(C) No. 18225/2024

November 8, 2024, the Court disposed of the SLP by directing that Harish receive adequate home care at the government's expense, while granting his parents liberty to return to Court if necessary. They did the same by filing a Miscellaneous Application (MA)[4] , which became the vehicle for the judgement delivered on March 11th 2026.

A Unanimous Medical and Family Consensus

Following the filing of the MA, the Supreme Court constituted the two-tier medical board process prescribed under the Common Cause Guidelines. A primary medical board comprising a neurologist, plastic surgeon, anaesthesiologist, and neurosurgeon visited Harish's home in Ghaziabad in late 2025 and concluded that his chances of recovery were negligible. A secondary medical board constituted by the All India Institute of Medical Sciences (AIIMS), New Delhi, examined him on December 17, 2025, and confirmed that he fulfilled the criteria for permanent vegetative state having been in that condition for thirteen years and that while CANH was necessary for his survival, it would not improve his medical condition or repair the underlying brain damage.

The family's position was equally unambiguous. In a meeting facilitated by the Additional Solicitor General on January 7th, and again before the Court's Bench on January 13th, Harish's parents, brother, and sister appeared in person. They spoke of the young man he had once been, expressed their exhaustion and grief, and appealed to the Court to let nature take its course. The family's view shared by both medical boards, the AIIMS doctors, and ultimately the Union of India was that continued treatment served no meaningful purpose and only prolonged suffering.

Two Questions at the Heart of the Judgement

Justice Pardiwala identified two threshold inquiries that governed the entire analysis- First, whether CANH administered through a PEG tube constitutes "medical treatment" within the meaning of the Common Cause 2018 framework; and second, whether withdrawal of that treatment would be in Harish Rana's "best interests". If both questions were answered affirmatively, the Court could authorise the withdrawal.

[4] M.A. No. 2238/2025

The questions mattered because Common Cause 2018, the foundational five-judge Constitutional Bench ruling had recognised passive euthanasia as constitutionally permissible under Article 21 of the Constitution[5], but had left considerable procedural and conceptual gaps. Chief among them was whether food and water delivered through a tube is a "treatment" that doctors can ethically withdraw, or whether it is basic care that must always be provided.

CANH Is Medical Treatment: Settling a Long-Contested Question

The judgement conclusively holds that CANH whether delivered via nasogastric tube, PEG tube, or otherwise is medical treatment, not mere sustenance. The reasoning is grounded in clinical reality as CANH involves surgical installation of a device, precise calculation of nutritional requirements, monitoring for gastrointestinal tolerance and metabolic stability, assessment of infection risks such as aspiration pneumonia and peritonitis, and periodic medical review. None of this, the Court held, is analogous to ordinary feeding.

The judgement also rejected the argument that CANH loses its medical character simply because it can be administered at home by a family member. Administration at home, the Court noted, still requires regular medical and nursing supervision, and the lay person performing it draws on medical knowledge and protocol. The fact of the setting does not alter the nature of the intervention.

This holding aligns Indian law with the approach taken in the United Kingdom following the House of Lords decision in *Airedale NHS Trust v. Bland* [1993][6], and brings clarity to a question that had left hospitals and families in a state of legal uncertainty for years. It means that when a PVS patient is sustained only through CANH, the decision to continue or discontinue that treatment is amenable to the same legal framework that governs any other end-of-life medical decision.

The Best Interest Standard: Holistic, Not Formulaic

On the best interest question, the judgement makes its most significant jurisprudential contribution. Surveying decisions from the United States, United Kingdom, Ireland, Italy, Australia, New Zealand, and the European Union; Justice Pardiwala articulates a best interest

[5] India Const. art. 21
[6] A.C. 789 (H.L.)

principle for incompetent patients that is deliberately wide. The correct inquiry, the Court holds, is not whether it is in the patient's best interests to die, but whether it is in the patient's best interests that life be prolonged by the continuation of the treatment in question.

This inquiry must incorporate both medical and non-medical considerations. On the medical side, decision-makers must assess whether treatment has become futile i.e. whether it serves any therapeutic purpose, or merely prolongs biological existence without improving the patient's condition. On the non-medical side, decision-makers must apply a substituted judgement standard- they must ask what the patient himself would have wanted, had he retained decision-making capacity, based on whatever can be known of his values, personality, and life.

Crucially, the substituted judgement standard does not mean asking what a reasonable person in the patient's position would want but rather attempting to reconstruct the specific individual's likely wishes. The judgement instructs decision-makers to consult family members and caregivers for this purpose and not to substitute their own moral preferences for those of the patient.

The presumption in favour of preserving life remains strong, but it is rebuttable. Where both medical futility and non-medical considerations converge to indicate that the patient would not have wished to continue in a state of permanent unconsciousness, the presumption may be displaced.

The Court frames this as a "balance sheet" exercise: Decision-makers must weigh the benefits and burdens of continued treatment, entering considerations on both sides before arriving at a conclusion.

Streamlining the Common Cause Guidelines

The judgement takes the opportunity to address procedural gaps in the guidelines originally laid down in Common Cause 2018 and modified in *Common Cause v. Union of India,* (2023)[7]. Among the most significant changes:

First, the Court bridges a gap that this very case exposed; the guidelines had previously contemplated withdrawal of treatment only for patients undergoing institutional care. Harish

[7] 14 SCC 131

Rana's situation receiving long-term care at home fell outside that framework. The judgement now extends the guidelines to home-based care settings, creating a mechanism for such patients to access the process.

Second, the Court addresses administrative delays caused by the failure of Chief Medical Officers (CMO's) to nominate doctors to secondary medical boards in a timely manner. It directs the Union of India to ensure that CMOs across all districts prepare and maintain a standing panel of qualified registered medical practitioners for this purpose, reviewed at intervals not exceeding twelve months.

Third, where both the primary and secondary medical boards are unanimous as they were in Harish Rana's case the judgement clarifies that court intervention is not mandatory. The process can proceed without judicial oversight, with the hospital simply notifying the jurisdictional Judicial Magistrate of First Class (JMFC). High Courts across the country have been directed to issue appropriate instructions to their JMFCs accordingly.

Active Euthanasia Remains Impermissible

The judgement is careful to reaffirm the boundary drawn in Common Cause 2018 between passive and active euthanasia. Active euthanasia, the administration of a lethal substance to cause death remains constitutionally impermissible and a criminal offence under existing law. The Court holds that the relevant distinction is not simply between acts and omissions, but between "causing death" and "allowing death to occur". Withdrawing life-sustaining treatment allows the natural trajectory of the underlying fatal condition to resume; it does not introduce a new cause of death. The same logic applies even where physically removing a machine requires a positive act: the legal and substantive character of the conduct remains an omission to treat. Active euthanasia, the Court reiterates, can only be legalised by Parliament. Until such legislation is enacted, it remains outside the bounds of what courts or doctors may authorise.

Parliament's Long Overdue Duty

The judgement is scathing in its account of legislative inaction. The Law Commission recommended legislation on end-of-life care in its 196th Report[8] in 2006. The Supreme Court's

[8] Law Comm'n of India, Rep. No. 196, Medical Treatment to Terminally Ill Patients ((Protection of Patients and Medical Practitioners) (2006)

ruling in *Aruna Ramchandra Shanbaug v. Union of India* (2011)[9], called for a law. The 241st Law Commission Report[10] in 2012 again recommended comprehensive legislation. Common Cause 2018 repeated the call. In 2024, draft guidelines[11] were published but no bill has been passed.

The result is that the legal framework governing one of the most profound decisions a family can face whether to allow a loved one to die rests entirely on judicial guidelines, with no statutory backing, no standardised institutional capacity across states, and no clear accountability mechanism. Justice Pardiwala notes that this gap has forced families like the Ranas into years of litigation simply to access a right that the Constitution already recognises.

In the final order, the Court directed that all medical treatment being administered to Harish Rana including CANH be withdrawn. AIIMS was directed to admit him to its Palliative Care department, arrange his transfer from home, and carry out the withdrawal through a carefully tailored end-of-life care plan designed to manage symptoms and preserve his dignity. The standard thirty-day reconsideration period was waived, given the complete unanimity among all stakeholders.

The judgement closes with words of unusual tenderness for a legal document. “Our decision today does not neatly fit within logic and reason alone,” Justice Pardiwala wrote. “It sits in a space between love, loss, medicine and mercy”, he paid tribute to Harish’s family for their thirteen years of sleepless nights nursing and caring for their beloved; moving towards their painful acceptance and their final act of love in asking the Court to let him go.

Why This Matters

The Harish Rana judgement matters for several reasons. It removes a critical ambiguity that had allowed hospitals and courts to reject withdrawal requests on the ground that CANH was not “medical treatment”. It enriches the best interest standard with a genuine patient-centric methodology that goes beyond clinical futility. It plugs a procedural gap that had left home-based patients in a legal no-man's-land. It also directly addresses the structural failure of India’s

[9] 4 SCC 454
[10] Law Comm'n of India, Rep. No. 241, Passive Euthanasia- A Relook (2012)
[11] Directorate General of Health Services, Ministry of Health & Family Welfare, Gov't of India, Guidelines for Withdrawal of Life Support in Terminally Ill Patients, D.O. No. Z-28020/13/2024-SAS-II (June 25, 2024).

CMO system to implement a framework that has existed in principle for nearly eight years.

It also, unavoidably, resumes the conversation about the need for legislation. India has millions of people in intensive care units, nursing homes, and family bedrooms whose conditions raise exactly the questions that this case presented. Without a statute, each family must navigate the same labyrinthine process assuming they know it exists at all. The judgement makes clear that this cannot continue indefinitely.

For now, the right to die with dignity in India remains a judicially constructed right, given its fullest expression yet in *Harish Rana v. Union of India*. The Shakespearean dilemma that Justice Pardiwala invokes at the outset "to be or not to be" has acquired a legal answer, at least for those in a permanent vegetative state. Where medicine cannot heal, and where both family and doctors agree, compelling a person to be kept alive goes against every dictate of dignity.