



# INTERNATIONAL JOURNAL FOR LEGAL RESEARCH AND ANALYSIS

Open Access, Refereed Journal Multi Disciplinary  
Peer Reviewed

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# **WHEN MEDICAL CARE BECOMES CONSTITUTIONAL LAW: A CRITICAL COMMENTARY ON HARISH RANA VS UNION OF INDIA**

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## **I. INTRODUCTION**

Recent advances in modern medicine have completely changed the concept of life and death. Technologies that can be used to keep living organisms alive for long periods have raised challenging constitutional issues about how far the State should go to require their continued life-supporting medical care once they have recovered, but treatment is no longer medically possible. Thus, issues of 'end of life' have become one of the most polarizing constitutional challenges before courts, balancing the sanctity of life with other equally strong principles of dignity, autonomy and bodily integrity.

Indian constitutional law has undergone a significant evolution in this area. Article 21 has since evolved from a mere guarantee to the government to not take away life without just cause into a repository of fundamental rights including privacy, decisional autonomy, health, dignity etc., since the matter of *Maneka Gandhi v. Union of India*<sup>1</sup>. The doctrinal development has further moved from *Aruna Ramachandra Shanbaug*<sup>2</sup>, a step that was taken to acknowledge passive euthanasia under judicial supervision, to the landmark of *Common Cause*<sup>3</sup>, where a Constitution Bench ruled that the right to life also entails the right to die with dignity. These decisions brought together the concept of the right to mere biological life to the right to meaningful human life. These decisions brought the concept of the right to mere biological life to the right to meaningful human life.

In this constitutional journey, the case of *Harish Rana v. Union of India*<sup>4</sup> is in continuity and refinement of the Indian end-of-life jurisprudence. In the absence of guidance from *Common Cause*, the Supreme Court was forced to address whether the use of a PEG tube for delivery of

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<sup>1</sup> *Maneka Gandhi v Union of India* (1978) 1 SCC 248.

<sup>2</sup> *Aruna Ramachandra Shanbaug v Union of India* (2011) 4 SCC 454.

<sup>3</sup> *Common Cause v Union of India* (2018) 5 SCC 1.

<sup>4</sup> *Harish Rana v Union of India*, Misc Application No 2238 of 2025 in Civil Appeal No 10190 of 2024 (SC, 23 May 2026) paras 45–81.

Clinically Assisted Nutrition and Hydration (CANH) to a patient in a Permanent Vegetative State (PVS) constitutes ordinary care or "medical" treatment that may be legally withheld. The Court resolved this issue by determining that CANH is a form of medical treatment that is essential for life, and withdrawal of it, if backed by independent medical opinion and judicial safeguards, is a constitutionally permissible but not illegal deprivation of life.

Death has been transformed with advances in medical technology. Physicians have now been able to maintain biological life with ventilators, PEG feeding tubes, artificial hydration and long-term neurological care even when there's no hope for recovery. These technologies are highly promising advances in medicine. Still, they also raise important ethical, legal and socio-economic questions about prolonging suffering, the responsibilities of the family, health care costs and patient dignity. The hurdles that exist in India are exacerbated by the disparity in access to palliative care services, the lack of support for long-term care in institutions and the lack of a comprehensive law covering end-of-life decisions. Within this changing socio-legal landscape, the case of Harish Rana v. Union of India becomes of constitutional importance.

This commentary contends that though Harish Rana has greatly enhanced the constitutional safeguards for dignified death by bringing in medical ethics under Article 21, the transformative impact of his comments does not end there, and that a comprehensive law is necessary. This has to be read not as the end of the passive euthanasia jurisprudence in India, but rather as a constitutional shift that requires strong statutory enactments, institutional protection and access to EoL care.

## **II. FACTS OF THE CASE**

The case of Harish Rana vs the Union of India was triggered by the tragic situation of a young engineering student whose life got turned upside down due to a devastating accident. Harish Rana fell off the fourth floor of his hostel and sustained a serious head injury in August, 2013. Though taken care of immediately by the best medical institutions such as PGIMER Chandigarh & AIIMS New Delhi, his condition of being in a Permanent Vegetative State (PVS) continued for more than 13 years. A series of medical evaluations has consistently found him to be totally without meaningful cognitive function, without awareness of his surroundings and no realistic chance of neurological improvement. Clinically Assisted Nutrition and Hydration (CANH) delivered via a Percutaneous Endoscopic Gastrostomy (PEG) tube along with ongoing nursing and supportive medical treatment were required for his survival.

Rana could not communicate or make decisions for himself, and both of his parents took care of him, spending years trying to cure him without any improvement. His father felt that prolonging life using artificial medical aids was not beneficial and he took the case to court for permission to discontinue treatment. The Delhi High Court said it didn't consider the withdrawal of PEG-assisted nutrition to be a case of passive euthanasia as discussed in Common Cause, as Rana was not medically "dependent" on the mechanical ventilator.

The issue was taken to the Supreme Court by way of a Miscellaneous Application and the core dispute now became whether CANH had a legal nature rather than having to do with the prognosis of the patient, which remained undeniable. Based upon the Court's direction, both Primary Medical Board and Secondary Medical Board, acting independently, agreed unanimously that, the patient's condition was hopeless, treatment was futile, and withdrawal of CANH would adhere to the accepted principles of medical ethics.

### **III. ISSUES RAISED BEFORE THE COURT**

The Supreme Court was asked to decide several questions of constitutional and medico-legal importance:

1. Whether Clinically Assisted Nutrition and Hydration (CANH) via a PEG tube is medical treatment or just "ordinary care.
2. If the withdrawal of CANH is a constitutionally acceptable passive euthanasia under Article 21 and/or is an unlawful deprivation of life.
3. constitutional right of an incompetent patient in a Permanent Vegetative State to die with dignity via substituted decision making.
4. Is the procedural safeguards that have been developed in Common Cause sufficient to control end-of-life decisions for medically futile treatment?

### **IV. JUDGMENT OF THE CASE**

The Supreme Court has reiterated its previous decision, which held that the right to life guaranteed by Article 21 of the Constitution also covers the right to die with dignity. The Court relied on the Common Cause case to determine that the norm of dignity is the underpinning of the right to live and that it continues to insure individuals even when they cannot make autonomous life decisions.

The Court's most important ruling was its definition of “medical treatment” vs. “ordinary treatment” for Clinically Assisted Nutrition and Hydration. As CANH must be delivered using specialist medical devices and needs regular clinical supervision, it can't be simply termed as ‘starvation’ but rather stopping life sustaining medical interventions. Withdrawal of CANH, when permitted under the provisions of independent medical assessment and judicial safeguards is therefore passive euthanasia, NOT active euthanasia. The Court reiterated that passive euthanasia does not "cause" death but rather implies "abandonment" of the patient's disease.

Last but not least, in authorising withdrawal of treatment in Rana's case, the Court affirmed the procedural guidelines laid down in Common Cause cannot be a viable alternative to legislation. It once again urged Parliament to introduce a comprehensive statute on passive euthanasia, advance medical directives, and substituted decision-making, emphasising the need for a regulatory framework for end-of-life care.

## **VI. SIGNIFICANCE OF THE JUDGEMENT**

Harish Rana v. Union of India is a landmark judgment in Indian constitutional law relating to end-of-life issues. Aruna Ramachandra Shanbaug was the first to recognise passive euthanasia under strict judicial supervision, whereas Common Cause brought the right to die with dignity as a facet of Article 21 under the constitution; Harish Rana also tackles the unanswered question of whether Clinically Assisted Nutrition and Hydration (CANH) is medical treatment. The Court has eliminated a significant uncertainty for hospitals, physicians and patients that was faced when considering whether a medical treatment that involves the use of a PEG tube can be considered "life-prolonging" treatment for which withdrawal is permitted.

The judgment also reinforces the constitutional nexus of the concepts of human dignity, medical ethics and patient autonomy. The judgment plays a significant role in explaining the constitutionalization of medical governance beyond its legal consequences, as it marks the importance of judicial involvement in the ethical issues that arise from medical care, and the fact that in the modern era, medical technologies are increasingly in need of judicial involvement. At the same time the Court reiterates that comprehensive legislation is a prerequisite to the regulation of passive euthanasia, advance medical directives and end-of-life care, and Parliament is called upon to establish a legislative framework to regulate these issues.

## V. CONSTITUTIONAL ANALYSIS

The ruling in *Harish Rana v. Union of India* has constitutional significance as it brings the principles established in *Common Cause* to a practical application when it comes to end-of-life decisions. The Supreme Court, instead of establishing a new constitutional right, brought together the concepts of human dignity, patient autonomy and medical ethics in a unified constitutional doctrine through the concept of Article 21. By making this ruling, the decision confirms life protection, and also the protection of the way of achieving natural death.

### A. Article 21 in current context

The judgment is part of the Supreme Court's liberal reading of Article 21. In the first case (*Maneka Gandhi v. Union of India*), the Court put forward the concept of the 'Right to a Dignified Life', which meant that the right to life was to be protected not just in the physical sense, but in the social, psychological and cultural dimensions as well. In *Aruna Ramachandra Shanbaug versus Union of India*, passive euthanasia was tentatively recognized under judicial supervision and in *Common Cause versus Union of India*, the right to die with dignity was deemed to be an integral part of the right to life.

*Harish Rana* expands on this jurisprudence to answer an important practical question. The Court distinguished between Clinically Assisted Nutrition and Hydration (CANH) and ordinary care and held that the withdrawal of CANH is constitutionally valid as it is a treatment rather than care. As such, Article 21 safeguards people against receiving medically unindicated treatment that extends their time on earth, but offers little chance of recovery.

### B. Human Dignity as the Basis of End-of-Life Rights

Judgment is a constitutionally rooted approach to human dignity. The Court restates its emphasis on the fundamental dimension of dignity as the basis of all other fundamental rights and not just on the level of physical survival. Rather, constitutional guarantees are afforded for respecting the inherent value of the person during dying.

This thought is substantially in line with the view of Ronald Dworkin that respect for human dignity<sup>5</sup> means respecting the value of a person's life as a whole, not keeping him alive for the sake of keeping him alive. In the same way, Martha Nussbaum's

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<sup>5</sup> Ronald Dworkin, *Life's Dominion* (Harper Collins 1993) 179–218.

<sup>6</sup>capabilities approach is a theory of dignity under which dignity is defined as the capacity to achieve human functioning worthy of human beings, rather than the mere maintenance of bodily functions. The Court does not explicitly cite these theorists but its reasoning is grounded in a similar conception that the dignity of the person is not synonymous with the right to medical intervention at all times.

C. Entry into and the rights of the family.

However, the focus of *Harish Rana* was on an individual who was not able to make his own living will at the same time, whereas *Common Cause* was focused on advance medical directives. The Court thus adopted the concept of substituted decision-making, which involves independent medical boards and judicial oversight to decide the best interests of the patient. This means that, in the event of loss of decision-making capacity, autonomy does not cease to exist. Rather, constitutional protection is safeguarded via procedural protections that are intended to illustrate what is most in keeping with the patient's dignity and well-being.

D. Judicial Constitutionalism

The judgment is also a good illustration of judicial constitutionalism, which involves constitutional courts establishing legal principles when the legislature has failed to do so. The Supreme Court made Article 21 practically viable even in the absence of comprehensive law by fine tuning the procedural framework laid out in *Common Cause*. The Court, at the same time, also recognised the limitations of judicial law-making by reiterating the need for the Parliament to come up with a statutory framework for passive euthanasia, advance medical directives and end of life care.

Consequently, *Harish Rana* demonstrates how the doctrine of constitutional adjudication safeguards fundamental rights, but how they are realised in practice rests with the enactment of laws and the capacity of institutions.

## **VI. CRITICAL EVALUATION**

*Harish Rana v Union of India* is one of the most noteworthy decisions in India's constitutional law pertaining to end-of-life care. The Court's elimination of a key uncertainty in *Common Cause*, that Clinically Assisted Nutrition and Hydration (CANH) is medical treatment that can

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<sup>6</sup> Martha C Nussbaum, *Creating Capabilities* (Harvard University Press 2011).

lawfully be withheld, was an important step. However, the ruling not only bolsters the constitutional right to a dignified death, it also poses significant questions about judicial rule-making, legislative inaction, disability rights and the provision of fair access to care.

The leading virtue of the judgment is that it reiterates the fact that Article 21 still has as its norm human dignity<sup>7</sup>. The Court is right to come away from the narrow, biological understanding of life and its constitutional importance and adopt the broader concept of life having an importance beyond mere physiological existence. With the same logic, the Court extends this principle to patients unable to make their wishes known at the time and further rules that constitutional dignity is not a constituent part of the right to live, but rather a fundamental right unto itself.

Second, the judgment is a commendable approach to putting the medical expert at ease. Instead of the family or courts making decisions on their own to determine what should happen at the end of life, the Court requires separate medical boards and judicial supervision before family members can decide to not provide life sustaining treatment. This combination respects patients' choices, adheres to professional medical standards and minimises the risk of arbitrary or economic decision making.

These advantages do not erase the inevitable implication of judicial overreach that is always present, however, when the judgment is released. The Constitution Bench in Common Cause clearly envisaged that its Guidelines of the procedure would apply till the Parliament passed a comprehensive law on passive euthanasia. But eight years later, Parliament has not been able to meet that constitutional expectation. While medical regulation by the Supreme Court can be warranted to safeguard fundamental rights, continued judicial rulemaking in medicine can lead to confusion between adjudication and legislation in the Constitution.

Another issue is the ongoing lack of legislation. No matter how sophisticated judicial rules are, they will not replace an extensive statutory system for advance medical directives, institutional liability, documentation requirements, and physician immunity. Hospitals and health care providers remain in significant uncertainty in relation to possible civil or criminal liability for refusing life-prolonging treatment. The limitation is acknowledged in an implicit manner by

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<sup>7</sup> *K.S. Puttaswamy v Union of India* (2017) 10 SCC 1.

the Court, which has repeatedly, this time, invited Parliament to enact the necessary legislation. The judgment is also relevant to disability rights jurisprudence for analysis. There may be a concern that in focusing on “quality of life” a message may be sent that the lives of those living with a severe disability have less constitutional value. This criticism is worthy of consideration, but Harish Rana is careful to avoid this pitfall because the reasoning of the book is based not on the concept of disability, but on the determination of medical futility by an independent expert. The basis for withdrawal is thus not a physical or cognitive impairment, but the lack of therapeutic benefit to the patient. It is crucial to maintain equality, as guaranteed in Article 14 and 21.

While the Court is correct in not using economic hardship as justification for withdrawal of care, it brings in the hidden care economy underpinning end-of-life care in India. Often families are responsible for physical, emotional, and financial care for extended periods of time without any institutional support. Dignity, the constitutional guarantee, thus necessitates not only judicial approval for passive euthanasia but also greater public funds for palliative care, the support of carers and the development of community health facilities.

Last, there are practical implications of this judgment that create several socio-economic issues. The procedural protections put to the test before the Court assume the availability of specialized neurologists, multi-disciplinary medical boards and advanced tertiary health care institutions. This is not the case in significant areas of the rural population in India. This means that the constitutional right to a dignified death is likely to be very difficult to achieve for poorer patients without significant investment in palliative care and institutional capacity.

However, when looked at in a broader perspective, Harish Rana is an important constitutional step forward. However, its impact will only be realized if legislative measures can be taken to ensure that the principles of courts can be translated into a user-friendly, uniform, and democratic system of end-of-life care.