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EUTHANASIA AND THE "RIGHT TO DIE" IN MODERN LAW

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Abstract

Euthanasia has remained one of the most debated issues in medical jurisprudence, raising complex legal, ethical, and moral questions. The concept involves intentionally ending the life of a person suffering from an incurable or terminal illness to relieve pain and suffering. In India, the legality of euthanasia has evolved through judicial interpretations rather than comprehensive legislative action. The Supreme Court of India, through landmark judgments such as ***Aruna Ramchandra Shanbaug v. Union of India***[1] **and *Common Cause v. Union of India***[2]**,** has recognized passive euthanasia and the validity of living wills under Article 21 of the Constitution. However, in a recent court decision in India allowed passive euthanasia for the first time in an individual case, marking an important step in the practical implementation of the right to die with dignity. This article examines the constitutional framework, statutory provisions, and judicial developments related to euthanasia in India. It also analyzes ethical concerns, comparative legal approaches, and the need for a comprehensive legal framework to regulate euthanasia while safeguarding human dignity and preventing misuse.

Keywords: Euthanasia, Right to Die, Article 21, Passive Euthanasia, Living Will, Medical Ethics, Constitutional Law.

INTRODUCTION

Euthanasia – ―good death‖ – broadly refers to intentionally ending a person's life to relieve intractable suffering. It can be active (deliberate act by a doctor) or passive (withdrawing life support), and voluntary, non-voluntary or involuntary depending on consent. Ancient thinkers like Plato and Seneca, and modern utilitarians like Bentham, Mill, Singer and Rachels, have

[1] (2011) 4 SCC 454 (SC)
[2] *(2018) 5 SCC 1 / AIR 2018 SC 1665*

argued that easing unbearable suffering may justify euthanasia. Opponents invoke sanctity of life, religious doctrine (e.g. Hippocratic prohibition on administering deadly drugs), and―slippery slope‖ risks. These ethical debates underpin a complex legal landscape worldwide.[3]

Since 2002, countries such as the Netherlands and Belgium enacted laws permitting physician administered euthanasia under strict criteria (unbearable suffering, voluntary request, and second-doctor safeguard). Other jurisdictions (Luxembourg 2009, Colombia 2015, Canada 2016, New Zealand 2020) followed, while some (UK, most of Africa and Asia) forbid it outright. The European Court of Human Rights has held that neither the European Convention's right to life nor right to privacy compels legal euthanasia; states have margin of appreciation.[4]

In India, euthanasia law has evolved chiefly through the judiciary. Earlier cases, the Supreme Court of India held ―no right to die‖ under Article 21 of the Constitution[5]. In Aruna Shanbaug (2011) the Supreme Court refused mercy-killing for a comatose patient, but for the first time legalized passive euthanasia under strict guidelines (medical boards, court approval). In Common Cause v. Union of India (2018) a five-judge bench held that the right to die with dignity is implicit in Article 21, and upheld ―living wills‖ or advance medical directives allowing passive withdrawal of treatment for terminal or permanently unconscious patients. In 2023 the Court streamlined the procedures (relaxing board composition, reducing judicial oversight) to make Advance Medical Directives more workable. In 2026[6] the Court permitted the first case of passive euthanasia (withdrawing nutrition tube for a patient in vegetative state), clarifying that clinically assisted nutrition is ―medical treatment‖ that can be withdrawn under existing law (and waiving the usual 30-day wait). Throughout, active euthanasia remains illegal (akin to homicide) and assisted suicide is not separately recognized; however, passive withdrawal by patient or family consent is now lawful under SC guidelines.

The article features the definitions and history of euthanasia are traced, ethical arguments are examined, significant international laws and cases are outlined, and the Indian legal background (Statutes, BNS, Constitution, Supreme Court verdicts) is examined. It provides a

[3] Euthanasia | Definition, History, Legal Considerations, Types, Assisted Death, & Facts | Britannica
[4] https://researchbriefings.files.parliament.uk/documents/SN04857/SN04857.pdf
[5] Gian Kaur v. Punjab, 1996
[6] Harish Rana v. Union of India, 2026 SCC OnLine SC 358

comparison table of euthanasia legislation in six places (the Netherlands, Belgium, Canada, UK, USA states, India) and examines current discussions and clinical protections (medical boards, advance directives, pain relief). Lastly, it identifies research gaps (such as data on results, psychological consequences, and rural healthcare preparedness) and develops the objectives and importance of more research.

DEFINITIONS AND HISTORICAL BACKGROUND

Defining euthanasia and "right to die": Euthanasia (from Greek eu ―good‖ + thanatos ―death‖) generally means intentionally ending a person's life to relieve incurable suffering. It contrasts with physician-assisted suicide (PAS) where the doctor provides means (like lethal medication) but the patient self-administers. Active euthanasia (doctor's direct act) differs from passive euthanasia (letting a patient die by withdrawing/withholding treatment). Each can be voluntary (with informed patient consent), non-voluntary (patient lacks capacity, decision by others), or involuntary (against patient's will, generally considered homicide).

Ancient and medieval views: In antiquity some philosophers condoned rational suicide in cases of extreme suffering – for example Plato and the Stoics (Seneca) viewed death as a rational choice in unbearable situations. However, medical ethics traditionally opposed euthanasia: the Hippocratic Oath (c.5th century BC) forbade giving ―a deadly drug‖ to a patient, and classical medicine (and later Christian ethics) emphasized preservation of life. Pythagoras (6th c. BC) reportedly forbade physicians from assisting in suicide.[7] In medieval India, ancient texts describe the Jain practice of sallekhana and the Hindu prayopavesa (fasting to death) as religiously sanctioned forms of voluntary death in face of terminal illness or old age, but these are distinct from medical euthanasia.

Modern philosophical arguments: In the 19th–20th centuries, utilitarian thinkers like Jeremy Bentham and John Stuart Mill (cited by Britannica) argued that reducing suffering is paramount, and later ethicists like Peter Singer, James Rachels, and Gary Quill developed arguments in favor of voluntary euthanasia on autonomy and compassion grounds. Opponents emphasize intrinsic human dignity and sanctity of life; for example, many religious traditions teach that life's value is absolute. The World Medical Association, representing doctors internationally, currently ―firmly opposes euthanasia and physician- assisted suicide‖ as

[7] The Hippocratic Oath and the Ethics of Euthanasia

contrary to medical ethics, while urging robust palliative care and pain management.[8] This reflects a core ethical tension: respecting patient autonomy versus the duty to preserve life and ―first, do no harm.‖

Legal history globally: In the 20th century legal developments varied. After WWII, the Nazi program of involuntary ―euthanasia‖ (killing disabled people) led to universal condemnation of non-voluntary killing. In the 1960s–70s advocacy re-emerged, culminating in Oregon (U.S.) passing the first ―Death with Dignity‖ law by referendum in 1994 (effective 1997) permitting physician-assisted dying for terminally ill adults. In 2002 the Netherlands enacted the Termination of Life on Request Act (effective 2002), formally legalizing euthanasia and PAS under strict criteria, followed by Belgium's Euthanasia Act in May 2002. These Benelux laws require unbearable suffering, voluntary request, and a consulting physician, with mandatory reporting to review committees.[9] In 2016 Canada legalized Medical Assistance in Dying (MAID) following Carter v. Canada (2015). By 2026, at least a dozen jurisdictions (including Luxembourg, Colombia, and several U.S. states) allow some form of assisted dying.

Table 1 (below) compares key features across six jurisdictions:-

Timeline in Global Milestones
400BC: Hippocratic Oath forbids euthanasia 1997:
Oregon Death with Dignity Act (USA)
2002: Netherlands & Belgium legalize euthanasia (May)
2016: Canada legalizes MAID (June)
2018: India SC (Common Cause) legalizes passive euthanasia 2023:
India SC streamlines passive euthanasia process
2026: India SC permits first passive euthanasia case (Harish Rana)

Euthanasia in India (pre-2011): Under British-era law, Section 309 IPC made attempted suicide a crime. In P. Rathinam v. UOI[10], a two-judge SC bench struck down S.309 as violative of the right to life, but this was overruled in Gian Kaur v. State of Punjab. In Gian Kaur a five-judge Constitutional Bench held that Article 21 (right to life and liberty) does not include a ―right to die,‖ only a ―right to live with dignity,‖ and upheld S.309's constitutionality. Thus

[8] Euthanasia – WMA – The World Medical Association
[9] Belgium – WFRTDS
[10] 1994 AIR 1844,1994 SCC (3) 394

Indian law initially forbade both suicide (later repealed, see below) and any form of euthanasia except as permitted by a strict interpretation of life-right. As late as 1993, the UK House of Lords (Airedale NHS Trust v. Bland) held that doctors must continue basic care, citing law against killing – a view echoed by Gian Kaur.

ETHICAL ARGUMENTS AND DEBATES

The ethical debate on euthanasia centers on **autonomy and compassion versus the sanctity of life**. Proponents argue that mentally competent individuals have the right to decide their own fate, especially when facing unbearable and irreversible suffering. They view euthanasia as a means to uphold **human dignity** by allowing a peaceful death rather than prolonged agony. Thinkers like Peter Singer emphasize that relieving suffering can be a moral obligation, and that euthanasia values the quality—not merely the continuation—of life.

Opponents, however, stress that **human life is inherently sacred** and should not be intentionally ended under any circumstances. Institutions such as the World Medical Association (WMA) maintain that euthanasia contradicts medical ethics. They rely on the **principle of double effect**, allowing pain relief even if it may unintentionally hasten death, but rejecting any direct intention to cause death. Concerns about a **slippery slope** also arise, including risks of coercion, misuse, and the expansion of euthanasia to vulnerable groups like the elderly or disabled.

From a clinical ethics perspective, the role of doctors remains contested between preserving life and ensuring quality of life. While modern medicine increasingly supports patient autonomy, most medical bodies stop short of endorsing euthanasia and instead emphasize **palliative care and hospice support**. The WMA Declaration of Lisbon on End of Life Care reinforces this by advocating relief from suffering while prohibiting deliberate life-ending actions. Ultimately, the debate reflects an ongoing tension in medical law between enabling a **dignified death** and safeguarding ethical and legal boundaries.

MAJOR INTERNATIONAL LEGAL FRAMEWORKS AND CASES

Euthanasia and assisted dying laws vary widely. The following survey highlights landmark legal frameworks and cases:

- Netherlands (Euthanasia Act 2002): The Netherlands was the first country to formally legalize euthanasia. The Termination of Life on Request and Assisted Suicide Act (passed 2001, effective 2002) permits doctors to end patients' lives if all strict criteria are met: a voluntary and well considered request; unbearable suffering with no prospect of improvement; informed consent; consultation with an independent physician; and careful, prescribed procedures. Physicians must report each case to a review committee. Under Dutch law, both euthanasia and physician-assisted suicide by doctors acting under these ―due care‖ criteria are not punishable. Passive euthanasia (withdrawing care) is not controversial there, but active steps to cause death are strictly regulated.

- Belgium (Law of May 2002, amended 2014): Enacted one month after the Dutch law, Belgium's Euthanasia Act similarly decriminalized voluntary euthanasia for adults suffering ―unbearable physical or mental suffering‖ from a serious and incurable condition. The 2002 Act requires the patient's explicit request, a waiting period, and consultation with two doctors. Uniquely, Belgium in 2014 became the first to allow euthanasia for minors of any age (with parental consent and psychological evaluation). The Belgian law also permits advance directives (valid for irreversible coma) and applies to residents (though doctors rarely assist foreigners). An independent Federal Euthanasia Control Commission reviews all cases after the fact.

- Canada (Bill C-14, 2016; Bill C-7, 2021): In Carter v. Canada (2015), Canada's Supreme Court struck down the criminal ban on assisted dying as violating the Charter of Rights. Parliament responded with Bill C-14 (2016), legalizing Medical Assistance in Dying (MAID) for competent adults meeting criteria: age ≥18, capable, grievous and irremediable medical condition causing intolerable suffering, and whose natural death is reasonably foreseeable. Two physicians (or a nurse practitioner) must independently assess eligibility, and a waiting period (usually 10–15 days) applies. In March 2021 Bill C-7 removed the ―reasonably foreseeable death‖ criterion, expanding MAID to incurable conditions even if not terminal. Mental illness as sole condition has been deferred (eligibility postponed to 2027). MAID must be by prescription of medication, typically self-administered (although a doctor can administer it if the patient cannot). Use of MAID has grown (5% of Canadian deaths by 2024) and remains

politically and ethically contentious.

- United States (State Laws v. Federal): No federal legalization exists; however, 15 jurisdictions (as of 2026) permit physician-assisted dying for terminally ill, mentally competent adults. The first was Oregon[11]. As of 2026, states including California, Colorado, Delaware, Hawaii, Illinois, Maine, Montana (court ruling), New Jersey, New Mexico, New York, Oregon, Vermont, Washington, and the District of Columbia allow ―medical aid in dying‖ . Eligibility typically requires residency, age ≥18, decision-making capacity, a terminal illness (life expectancy ~6 months in most states), two doctors' confirmation, a written request, and often a waiting period. These laws explicitly state compliant physicians incur no criminal liability. Elsewhere in the U.S., assisting suicide remains a crime (felony) under statute or common law. In Washington v. Glucksberg (1997) and Vacco v. Quill (1997), the U.S. Supreme Court upheld bans on assisted suicide, finding no constitutional ―right to die,‖ but left open state legislatures to change law. (Notably, active euthanasia is illegal under U.S. law everywhere, as doctors may not directly administer lethal drugs.)

- United Kingdom: English law (for England and Wales) strictly forbids both euthanasia and assisted suicide. Section 2(1) of the Suicide Act 1961 makes―encouraging or assisting another to commit suicide‖ a felony (up to 14 years' imprisonment). Medical killing is treated as murder/ manslaughter. Notably, UK courts have allowed passive decisions: in Airedale NHS Trust v. Bland (1993) the House of Lords permitted withdrawal of feeding from a permanent vegetative patient, as it was letting die rather than killing. In Nicklinson/Lamb (2014 UK Supreme Court) and Pretty v. UK (2002 ECHR), attempts to recognize a constitutional or human-rights ―right to die‖ were rejected. However, under the Mental Capacity Act 2005 and the Common Law, patients may refuse treatment (even if it leads to death), and advance refusals are upheld. The UK government's stance remains that any law change is a matter for Parliament.

- European Human Rights Law: The European Court of Human Rights has heard cases like Pretty v. UK (2002) and Gross v. Switzerland (2014) on assisted suicide. It concluded that Article 2 (right to life) does not impose a duty to allow euthanasia, nora

[11] 1997 law, effective 1999

general right to die, and Article 8 (private life) does not guarantee assisted suicide in the absence of a national law. However, ECHR jurisprudence invites member states to articulate clear laws and safeguards.

In sum, countries that do allow active euthanasia or assisted suicide generally require: (a) voluntary, well considered consent by a competent adult; (b) an incurable, severely suffering condition (often terminal illness); (c) confirmation by multiple doctors; (d) waiting periods; and (e) oversight (registries or review boards). In contrast, jurisdictions that prohibit it criminalize assisting suicide (UK, most of Asia/ Africa) or treat euthanasia as murder. Passive euthanasia (forfeiting treatment) is widely accepted in medical law, but active interventions are the dividing line.

EUTHANASIA IN INDIA LAW

Constitutional Context: Article 21 of the Indian Constitution guarantees the right to life ―with dignity.‖ In Gian Kaur v. Punjab (1996), the Supreme Court interpreted this to reject any ―right to die,‖ instead stating: ―the right to life includes the right to live with human dignity,‖ and explicitly held euthanasia and assisted suicide unlawful without legislation. Thus Article 21 itself does not presently guarantee a right to end life. However, Common Cause (2018) revisited the interplay of dignity and dying, holding that a dignified death (freedom from―unnecessary pain and suffering‖) is part of Article 21's guarantee.

Indian Penal Code: - Section 307 IPC punishes attempted murder; Section 300-304 IPC penalizes murder/ culpable homicide. Active euthanasia would generally fall under these provisions. Passive euthanasia (e.g. withdrawal of life support) is not explicitly criminalized.
- Section 309 IPC (attempt to commit suicide) used to criminalize suicide attempts. In Gian Kaur the Court upheld S.309's constitutionality, but in practice Parliament addressed this: the Mental Healthcare Act 2017 (effective 2018) provides that persons attempting suicide are presumed under severe stress and shall not be tried or punished under S.309.

In the new regime under the Bharatiya Nyaya Sanhita, 2023, these provisions have been substantially retained in substance, though renumbered. Attempt to murder is now covered under **Section 109 BNS**, and offences relating to murder and culpable homicide are dealt with under **Sections 101–105 BNS**. Therefore, **active euthanasia**, which involves a deliberate act to end life, would generally fall within these provisions and attract criminal

liability.

As regards **passive euthanasia** (such as withdrawal of life support), it continues to remain **not explicitly criminalized**, and its legality is primarily governed by judicial pronouncements (notably *Common Cause v. Union of India*) and medical guidelines rather than penal provisions.

Further, under the IPC, Section 309 criminalized attempt to commit suicide. Although upheld in *Gian Kaur v. State of Punjab*, its practical application was diluted by the Mental Healthcare Act, 2017, which presumes that a person attempting suicide is under severe stress and should not be punished. The Bharatiya Nyaya Sanhita, 2023 continues this humanitarian approach—**attempt to suicide is no longer treated in a punitive manner**, aligning criminal law with mental health protections.

Thus, in India as of 2018 suicide attempts have been effectively decriminalized, reflecting changing attitudes toward self-harm. Statutory Law: India has no specific legislation on euthanasia or assisted suicide. There have been draft bills (e.g. a 2006 Law Commission proposal for terminal illness care) but none enacted. Passive euthanasia is thus governed by judicial precedent and general laws.

SUPREME COURT JURISPRUDENCE

Aruna Ramachandra Shanbaug v. UOI (2011): Aruna Shanbaug, a nursing officer left in a persistent vegetative state (PVS) since 1973, was the petitioner. The SC (Justice Khare) rejected a journalist's plea to withdraw her feeding tube, since her doctors opposed it. Crucially, however, the Court stated that passive euthanasia is not per se illegal. It recognized—the withdrawal of medical treatment (or food and water) that is keeping a patient alive‖ can fall under Article 21's right to die with dignity, if approved by the court. The Court then laid down elaborate procedural safeguards: requests for passive euthanasia must go to the High Court (or Supreme Court) with two medical board approvals etc. (This was groundbreaking, as no Indian court had before expressly legalized any form of euthanasia.) The Court did not allow this particular mercy plea (due to lack of consent), but it legalized passive euthanasia in principle, subject to procedure. (Active euthanasia and assisted suicide remained forbidden.)

Common Cause (A Regd. Society) v. Union of India (2018): A PIL had asked whether adults have a constitutional ―right to die with dignity,‖ including via Advance Medical Directives (living wills). The Court (5-Judge Bench) unanimously held that ―right to die with dignity‖ is implicit in Article 21. It upheld passive euthanasia (again only) but importantly validated advance directives: a competent adult can create a living will instructing cessation of treatment in specified circumstances. The Court set out new guidelines: an Advance Medical Directive must be notarized or witnessed, can specify who will consent, etc. When a patient cannot consent, a family member or representative can petition on their behalf. The Court rejected active euthanasia entirely. It emphasized that this judicially-crafted regime would stand until Parliament enacts a law, recognizing its own role as a stop gap measure.

Post-2018 developments: In Common Cause and Aruna the Court had mandated cumbersome procedures. In January 2023 a 5-Judge bench (led by Justice KM Joseph) streamlined the process (in a judgment often called Common Cause Modification). The Court accepted a joint proposal by medical bodies and the government: now Advance Directives need only be attested by a notary or gazetted officer (not a Judicial Magistrate), medical board experience requirements were reduced (from 20 to 5 years' experience), and the requirement for two boards to decide within 48 hours was emphasized. Judicial involvement was cut back: the magistrate now simply receives notice (with family consent) rather than vetting everything. These changes aim to make passive euthanasia (via living wills) practical.

Most recently, on 11 March 2026, in **Harish Rana v. Union of India** the Supreme Court approved the first individual passive euthanasia under these rules. Harish Rana, in a vegetative state since 2013, sought withdrawal of his feeding tube. The Court (Justices Pardiwala & Viswanathan) allowed it, directing AIIMS to withdraw clinically-assisted nutrition, admitting him to palliative care, and emphasizing preservation of dignity. Significantly, the Court held: clinically assisted nutrition and hydration (e.g. feeding by tube) is ―medical treatment‖, so it could be withdrawn under the Common Cause framework. It also waived the usual 30-day reflection period given the patient's long suffering. This case concretized the passive euthanasia doctrine: for the first time the SC applied its own 2018 rules to a real patient, and also linked euthanasia with mandatory palliative care integration.

Constitutional Provisions: Article 21 (life and liberty), Article 14 (equality) and Article 19(1)(a) (speech) have been invoked in euthanasia cases. The SC in 2018 explicitly tied the ―right

to die with dignity‖ to Article 21. No constitutional amendment is yet present, so evolving case law fills the gap. Parliament has not yet enacted any euthanasia law, despite SC's invitation. The Indian Penal Code has relevant sections on abetment and homicide, but no new provisions on mercy-killing have been added.

CURRENT DEBATES AND STAKEHOLDERS

Euthanasia remains hotly debated in India and globally.

Stakeholders: Patient-rights groups (e.g. Common Cause, Compassionate Dying Forum) advocate for legalizing voluntary passive euthanasia and living wills. Many doctors and medical bodies (e.g. Indian Medical Association) stress palliative care and fear misuse. Religious leaders are mostly cautious: major faiths (Hindu, Muslim, Christian) traditionally oppose ending life intentionally, though they may condone natural death. Notably, Hindu and Jain ethical traditions include voluntary death-by-fast rituals (Prayopavesa, Sallekhana), but these are culturally distinct from modern euthanasia. Disability rights activists worry that legal euthanasia might pressure the disabled to choose death if society fails to care for them. Politically, euthanasia is not currently a sharp electoral issue in India, but it garners periodic media attention (e.g. celebrity cases).

Key debates:

1. Legal v. medical authority: Should only Parliament legislate euthanasia, or can the Courts frame rules (as done in Common Cause)? Some argue only a democratic process can calibrate such sensitive laws; others note the judiciary's duty under Article 32 to secure rights.
2. Safeguards adequacy: Critics say India's high doctor-patient ratio gaps and legal illiteracy could lead to forged ADs or coercion by relatives. The strict procedures (multiple doctors, court approval, 30 day delay) were partly meant to prevent abuse, but also made the process impractical. The 2023 reforms attempt to balance safeguards with feasibility.
3. Palliative care v. euthanasia: Some contend that better palliative care infrastructure should precede any euthanasia legalization, so patients have genuine choice. India's palliative care (especially rural areas) is under-resourced, a point often raised.
4. Scope of euthanasia: Should euthanasia ever extend beyond terminal illness? In 2021 Common Cause panel had discussed euthanasia for psychiatric illness or chronic pain,

but the SC limited it to terminal/vegetative states. Outside India, countries like Belgium and the Netherlands allow euthanasia for psychiatric cases (with added safeguards), whereas in India this is not on the table.

Emerging issues: Advances in life support and critical care mean more patients end up in PVS or ventilator-dependent; end-of-life decisions have become common in ICU ethics. Covid-19 and overwhelmed hospitals have reignited questions about withdrawing life support. The intersection of euthanasia law with India's new Mental Healthcare Act (which treats attempted suicide as stress) and Rights of Persons with Disabilities Act also raises intricate questions.

MEDICAL AND PROCEDURAL ISSUES

Even where euthanasia is allowed, strict safeguards are designed to ensure decisions are informed and voluntary. Internationally these include: requiring multiple doctors' assessments, waiting/reflection periods, psychiatric evaluation (to rule out treatable depression), and oversight commissions. India's SC guidelines similarly mandate medical boards with experienced physicians to certify prognosis and voluntary consent, and (previously) Judicial Magistrate approval. The 2023 order reduced these burdens (Board members need only 5 years' experience, notaries can attest ADs) while retaining second opinions.

A key tool is the Advance Medical Directive (living will). From 2018 onward, a competent adult in India can register instructions (e.g. ―if I am terminal or in coma, withdraw life support‖) . Such directives must be in writing, witnessed, and specify relatives or doctors as decision-makers. If no directive exists, family or guardians may apply on the patient's behalf. Notably, India's Supreme Court made ADs legally valid before any statute did – a unique example of court-created advance directives.

Procedures for passive euthanasia in India (as of 2023 guidelines): a terminally ill or permanently vegetative patient's decision (or AD) is first assessed by the treating doctor. A Primary Medical Board (treating physician + ≥2 specialists) then certifies that continuing treatment is futile. The proposal is forwarded to a Secondary Board (headed by the Chief Medical Officer or delegate) for concurrence. If both boards agree, the hospital informs the Judicial Magistrate (who no longer ―approves‖ but merely records the decision) and the patient's close relative. Only then can treatment be withdrawn. Both boards should decide 13

8 13 within ~48 hours. Previously there was also a 30-day wait for reconsideration; in Harish Rana, this was waived given patient's circumstances. Overall, medical and procedural issues highlight that euthanasia is not a single event but a process requiring careful checks. In India's context of resource constraints, experts caution that adequate training and public awareness are critical.

COMAPARATIVE OVERVIEW OF EUTHANASIA LAW IN FOREIGN LAW:

Jurisdiction	Active Euthanasia	Physician-Assisted Suicide (PAS)	Eligibility & Scope	Major Safeguards / Procedures
Netherlands	Legal (2002 Act)	Legal	Voluntary adult; unbearable suffering (physical or psychological); no reasonable alternative; advance directives allowed	Written request; second independent doctor; only physicians administer; mandatory reporting to review committees
Belgium	Legal (2002 Act)	Legal	Adults with incurable condition and constant unbearable suffering; minors allowed (with consent); advance directives (coma cases)	Two doctors (psychiatrist if mental illness); waiting period; Federal Review Commission oversight; reporting required
Canada	Active euthanasia technically illegal (but MAiD includes	Legal (2016 law)	Adults with ―grievous and irremediable‖ condition; suffering intolerable; death need not be	Two independent medical assessments; written informed consent; waiting period; federal

Jurisdiction	Active Euthanasia	Physician-Assisted Suicide (PAS)	Eligibility & Scope	Major Safeguards / Procedures
	clinician-administered death)		imminent; mental illness excluded (till 2027)	monitoring system
United Kingdom (England &	Illegal (treated as homicide)	Illegal (under Suicide Act,	No legal recognition; passive euthanasia allowed via	Withdrawal of treatment requires consent or best-
Wales)		1961)	Consent/best interest (e.g., Airedale NHS Trust v Bland; Mental Capacity Act, 2005)	interest decision; advance directives binding; DPP guidelines may affect prosecution
USA (Selected States)	Illegal in all states	Legal in ~14 jurisdictions (e.g., Oregon, California, Washington)	Terminally ill adults (usually ≤6 months prognosis); mental capacity required; residency rules apply (varies by state)	Two physicians' confirmation; written request; waiting period; self-administration; state-level reporting
India	Illegal (treated as homicide under Bharatiya Nyaya Sanhita, 2023)	Not expressly legalized; assisting suicide not protected	Passive euthanasia legal under Supreme Court rulings (Common Cause, 2018); applies to terminally ill or PVS patients; living wills recognized	Two medical boards certify condition; Magistrate informed; procedural safeguards; advance directives valid; active euthanasia remains criminal

CONCLUSION

The discourse on euthanasia and the right to die with dignity in India reflects a delicate balance between individual autonomy, ethical considerations, and the State's obligation to protect life. While judicial interventions, particularly in *Gian Kaur* and *Common Cause*, have gradually recognized the legitimacy of passive euthanasia and advance directives, the legal framework remains cautious and fragmented. The continued criminalization of active euthanasia and the absence of comprehensive legislation indicate that India is still navigating this sensitive terrain with restraint.

At the same time, evolving medical realities—such as increased life expectancy, advancements in critical care, and the growing incidence of prolonged terminal illness—have intensified the urgency of addressing end-of-life decisions. The recognition of ―dignity‖ as an intrinsic component of the right to life under Article 21 invites a deeper constitutional inquiry into whether the right to die with dignity can be meaningfully operationalized within existing legal structures. This necessitates not only doctrinal clarity but also alignment with ethical, cultural, and socio-economic contexts unique to India.

The study highlights significant research gaps, particularly in empirical data, stakeholder perspectives, and implementation challenges of judicial guidelines. Addressing these gaps through interdisciplinary research is essential for informed policymaking. A nuanced approach—integrating legal safeguards, medical ethics, and social realities—can help ensure that end-of-life choices are exercised with autonomy, compassion, and accountability. Ultimately, India's engagement with euthanasia must move beyond judicial accommodation toward a coherent legislative framework that upholds both the sanctity of life and the dignity of death, contributing meaningfully to global bioethical discourse.