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REIMAGINING END-OF-LIFE RIGHTS: THE LEGAL AND MORAL DISCOURSE ON ACTIVE EUTHANASIA

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"The true measure of dignity is not only in how one lives under the law, but also in how one is permitted to depart from life with grace."

Abstract

At the beginning of active euthanasia, we are at a branch point — a road which leads us into an argument complex and multidisciplinary in nature. It is not confined to a single branch of law but traverses constitutional values, human rights adjudication, medical ethics, and above all, the virgin field of whether the right to die with dignity is compatible in the matrix of the right to life under Article 21 of the Indian Constitution. While countries such as the United Kingdom, the Netherlands, Belgium, and Canada have witnessed active or assisted dying in the forms of well-regulated mechanisms, India continues to prohibit active euthanasia from its legislative and judicial domain.

The Supreme Court in *Gian Kaur v. State of Punjab (1996)*[1] declined to grant the right to die under Article 21, but *Aruna Ramchandra Shanbaug v. Union of India (2011*[2]*)*, a landmark judgment, established the principle of passive euthanasia with caution under strict supervision. Despite this, the historical presence of Section 309 of the Indian Penal Code criminalizing attempts at self-killing had already pointed to the inconsistency of punishing people in an attempt to flee from unbearable suffering. Although this provision has since been repealed and substituted by Section 224 of the Bharatiya Nyaya Sanhita, 2023, that abolishes criminality against attempts at suicide, its legacy continues to taint the discussion of end-of-life rights, having a devastating impact on terminally ill patients, victims of incurable medical conditions, and prisoners awaiting final sentencing.

[1] Gian Kaur v. State of Punjab, AIR 1996 SC 946; 1996 SCC (2) 648
[2] Aruna Ramchandra Shanbaug v. Union of India, (2011) 4 SCC 454

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It is submitted that active euthanasia, under robust medical and judicial safeguards, must be viewed as an extension of the constitutional right guaranteed under Article 21. To live with dignity must also encompass the right to die with dignity. Else, the guarantee of freedom under the Constitution is incomplete — *defensive in life but dumb in death*.

Keywords: Active Euthanasia, Passive Euthanasia, Article 21, Right to Die with Dignity, Indian Penal Code, Bharatiya Nyaya Sanhita, Human Rights, Medical Ethics, Constitutional Law.

Introduction -

End-of-life decision-making is at the sensitive intersection of constitutional law, ethics, human rights, and medicine. It presents one of the most difficult questions of a constitutional democracy: how can law guard the sanctity of life and yet defend the autonomy and dignity of the individual? The euthanasia debate testifies to this tension. It is not a monolithic concept but emerges in diverse forms, which are all lumped together as active, passive, and indirect euthanasia.

Types of Euthanasia

Type of Euthanasia	Definition	Example
Active	Direct action to kill	Lethal injection
Passive	Withholding or withdrawal of life-sustaining treatment	REMOVAL of ventilator support
Indirect	Administration of pain relief that has the unintended consequence of shortening life	High-dose opioids in terminal care

In the majority of the world, active and passive euthanasia are legal in some areas, with others permitting only passive methods under strict control.

Countries Legalizing Euthanasia

Category	Countries
Active & Passive Euthanasia Legalized	Netherlands, Belgium, Luxembourg, Canada, Colombia, Spain, New Zealand
Passive Euthanasia Only	India (under judicial safeguards)

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India has taken a conservative legal path. The Supreme Court declined to interpret the right to die into Article 21 of the Constitution in *Gian Kaur v. State of Punjab (1996).* Later, in *Aruna Ramchandra Shanbaug v. Union of India (2011),* passive euthanasia was approved, albeit under strict medical and judicial scrutiny. The term was then explained in *Common Cause v. Union of India (2018[3]),* which confirmed right to die with dignity under Article 21 and founded advance directives (living wills). The Court advanced the system in 2023, simplifying processes to make them less cumbersome and accessible.

Simultaneously, criminal law has also developed alongside. Section 309[4] of the Indian Penal Code once made attempt at suicide a crime, which rendered the law self-contradictory to punish persons for attempting to end unbearable suffering while talking of dignity under Article 21. The provision has since been abolished and only attempts to intimidate or to obstruct public servants are punishable under Section 224[5] of the Bharatiya Nyaya Sanhita, 2023. This is a consequence of a more compassionate understanding of autonomy and mental health in the end-of-life debate.

However, even in jurisdictions in which euthanasia has been made legal, there are unresolved issues of interpretation. For instance, New Zealand, while it legalizes active euthanasia, still experiences challenges in defining and interpreting what in practice amounts to euthanasia.

Also, in Japan in 2019, a female patient with *Amyotrophic Lateral Sclerosis (ALS[6])* was given a lethal dose of medicine by her doctors as she had requested. The lack of explicit legislative rules generated a national debate regarding whether euthanasia should be legally established in Japan.

These examples point to an important issue: *if the most developed countries in the world with efficient healthcare and legal systems still cannot come up with clear definitions of euthanasia, then what danger would it pose for underdeveloped or developing countries like India, where institutional protection and healthcare facilities are weaker?* The question for India, then, is not merely whether euthanasia must be legalized, but whether it can be framed

[3] Common Cause v. Union of India, (2018) 5 SCC 1; AIR 2018 SC 1665
[4] Indian Penal Code, 1860, Section 309 (repealed)
[5] Bharatiya Nyaya Sanhita, 2023, Section 224
[6] ALS Patient Case (Japan, 2019): "Kyoto ALS Case, Hayashi case, 2019: Doctors prosecuted under Japanese penal law for assisted suicide."

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in a manner that defends dignity without leading to loopholes that can erode human life itself.

Research Methodology

This research takes a doctrinal research methodology with an emphasis on primary legal documents and authorities' commentaries. It is both descriptive and analytical and, in addition, makes use of a comparative viewpoint in order to find out how India's system compares with or contrasts other jurisdictions. The very basis is the Indian Constitution, Article 21, which constitutionalizes the right to life and freedom of person. Statutory law as well has been interrogated, such as repealed Section 309 of the Indian Penal Code, 1860, and the subsequent change under the Bharatiya Nyaya Sanhita, 2023 (Section 224), which makes criminal liability for attempt at suicide qualify.

Judicial precedents are a chief source:

- Gian Kaur v. State of Punjab (1996), in which the Supreme Court held that the right to die was not enshrined under Article 21.
- Aruna Ramchandra Shanbaug v. Union of India (2011) which had temporarily allowed passive euthanasia.
- Common Cause v. Union of India (2018), in which the Court restated the right to die with dignity and approved living wills.
- The 2023 judgement, which streamlined procedures for accessing this right.

To place India's position in context in the world, comparative literature has been researched from those countries where euthanasia is legal, such as the Netherlands, Belgium, Luxembourg, Canada, Colombia, Spain, and New Zealand. Case studies such as the ALS patient case in Japan in 2019 have been cited for the purposes of illustrating lacunae of interpretation.

Secondary sources utilized are peer-reviewed journals in PubMed Central (NCBI)[7], ScienceDirect[8], and other academic databases encompassing law, ethics, and medical practice. Such publications provide the interdisciplinary environment needed in an attempt to study the convergence of constitutional norms, human dignity, and medical facts in the euthanasia debate.

[7] PubMed Central NCBI, Academic articles on euthanasia and medical ethics
[8] Science Direct, peer-reviewed scholarly articles regarding euthanasia

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Fundamentally, this comparative doctrinal method based on comparative and inter- disciplinary understanding presents structured analysis on whether active euthanasia can be permitted in Indian legal and constitutional contexts.

Research Objectives

- To examine the way in which active and passive euthanasia have been canvassed, legislated, and practiced in India, specifically through the major court judgments.
- To examine how countries like the Netherlands, Belgium, Canada, and New Zealand approach active euthanasia, and to note what lessons can be learned by India from their regulations and procedures.
- To make clear whether providing people with the choice of a dignified death is within the rights enshrined in the Indian Constitution, that is the right to life under Article 21.
- In order to determine what issues and threats India would be facing if active euthanasia were legalized, in terms of health care gaps, abuse potential and cultural beliefs.
- To set out steps and protection that could assist in keeping people safe and maintaining dignity if India legalized active euthanasia.

Research Questions

- What has India done in response to end-of-life choices, and what impact has high-profile court cases had on the euthanasia law?
- What is legal active euthanasia states doing to protect patients and prevent abuse, and what lessons can be learned from their experience?
- What are the health, social, and ethical concerns at stake in the case for legalizing euthanasia, specifically patient autonomy, risk of exploitation, and quality of care at the end of life in India?
- Supposing active euthanasia was to be legalized in India, what legislation and controls must be implemented to protect vulnerable people and the right to dignity?
- In what ways does India devise a euthanasia policy that is in harmony with its cultural sensibilities and legal traditions, but learns from the experience of other countries as well?

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Literature Review

The narrative about euthanasia is where medicine, ethics, and law intersect, and literary scholarship reflects as much diversity. Medical and palliative writers emphasize that debates at the end of life can't be disentangled from the facts of suffering, pain relief, and access to good end-of-life care. Indian medical commentators have continued to point out that the majority of euthanasia demands are made in settings where palliative care is poor or spottily available; therefore, improving palliation is also presented as an ethical and feasible alternative to legalizing active life-shortening interventions. This bedside perspective anchors much of the Indian literature and cautions that legal reform cannot be meaningful without simultaneous health-system strengthening. Scholars of law, nonetheless, record the constitutional rationale's impact on India's gradualism. Contrary early rulings — from liberal high-court dicta to the Supreme Court's restrictive stance in *Gian Kaur* — and the later incremental adoption of passive withdrawal in *Aruna Shanbaug* and the vindication of dignity in Common Cause are the foundations of doctrinal scholarship.

Academics tend to come at these cases as evidence of a tug-of-war between jurisprudence: the courts have struggled to save life while gradually defining narrow spheres of refusal of treatment and advance directives. This literature frames the problem as one of design in law—how to craft rules that are respectful of autonomy without endangering vulnerable groups to coercion or error.

Comparative literature makes test cases and warning signs. The Dutch and Belgian[9] regimes are most frequently cited: both jurisdictions involve statutory regulation with strict procedural tests, reporting rules, and professional guidelines meant to guard against misuse. Even these sophisticated regimes, however, generate controversies: scholars locate expansionary pressures, contentious interpretations of "unbearable suffering," and ethical tensions around requests driven by social rather than purely medical distress. These arguments make it evident that legalization itself does not eliminate vagueness; rather, it places the burden of regulation on institutions and practitioners who must bring vague concepts to individual cases. Canada and New Zealand[10] are especially useful to comparative law because they embody alternative trajectories of legislation. Canada's MAID system was born as a court-

[9] Belgian Act on Euthanasia, 28 May 2002, Belgisch Staatsblad, 22 June 2002
[10] The Terminations of Life on Request and Assisted Suicide Act, 2002 (Netherlands), Stb. 2001, 194, effective April 1, 2002

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initiated innovation and has developed since then by means of statutory revision and administrative regulation, creating equal, continuous public controversy around reach and protection. New Zealand's End of Life Choice system, enacted after a referendum, has also been subject to rigorous scrutiny by way of early review that assesses the operation of the law in practice. Both jurisdictions illustrate that even with formal legalization, operation management — clinician training, regulation, and social supports — determine whether the policy protects or harms vulnerable populations.

Empirical and research studies from permissive jurisdictions provide cautionary information. Recent reporting and scholarship record instances where socioeconomic disadvantage, insecure housing, or limited access to mental-health treatment appears in case histories of assisted-dying requests. These experiences have prompted some authors to demand that euthanasia policy be substantiated through investment in social and health infrastructure, lest social failure be framed as personal preference. Briefly, comparative literature uniformly points to an essential lesson: legal authorization in the absence of robust, context-sensitive safeguards and robust palliative alternatives can lead to outcomes that contradict the stated aim of maintaining dignity. Finally, cross-disciplinary insights recall that what is being asserted in law and medicine matters.

Vague statutory language, evolving clinical conventions and discriminatory institutional policies create interpretation gaps that even complex systems struggle to fill — as real-life elsewhere-controversies (e.g., ALS patient cases that have elicited criminal and public-policy scrutiny) attest. For India, the pens converge on a cautious prescription: any step towards legalizing active euthanasia must be incremental, tied to clear definitions, procedural safeguards, increased palliative care, and continued regulation, or else the reform will do more harm than good.

Results

The current study draws three kinds of results from the comparative and doctrinal overview:

A. Empirical trends of the jurisdictions permitting assisted dying
B. Normative conclusions on the hazards and advantages of legalizing active euthanasia in India;
C. Practical, case-sensitive recommendations on when assisted dying can — or cannot — be considered.

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Together these results view euthanasia as a powerful clinical-legal tool: it will bring an end to suffering with proper regulation, but will cause grave injustice if used to the contrary.

A. Patterns observed empirically

1. Incidence and scale- In regulated assisted dying, medically assisted deaths account for a small but growing percentage of all deaths. Euthanasia accounted for roughly 5.1% of Dutch deaths in 2022, for example. Canada's MAID[11] program had over 13,000 provisions in 2022, some 4.1% of deaths that year; total MAID cases since 2016 are already in the tens of thousands. New Zealand's early reports are that assisted deaths also comprise fewer than 1% of all deaths but are subject to continued scrutiny. These figures indicate legalized access not translating into bulk use, but regular, policy-guided use.
2. Contextual drivers- Case examples and comparative reports highlight the main points of the reports - the cases of requests for assisted dying which are specified as unmanageable physical pain, progressive neurological disease, loss of autonomy, and at times, psychiatric distress. Moreover, research is also focusing on the social drivers of the issue - for instance, limited accessibility to palliative care, isolation, and socio-economic is elicited in most of the case narratives. This means that the assisted-dying phenomenon cannot be understood apart from the quality of the health system and social support.
3. Adverse, high-profile cases- Contentious cases appear even if there is legislation. The 2019 ALS physician-assisted death in Japan — and the consequent criminal prosecution of the involved physician — are a good example of the danger that may extend behind the lack of legal clarity and control: a practice allowed or tolerated in one place can be illegal in another, where there is no legislative immunity. Such cases escalate the risk level in systems that lack procedures for protection.

B. Normative findings

1. Tool + user metaphor- Active euthanasia, however, is a medical-legal instrument: the result is less depending on whether the instrument exists or not but rather on who is using it, how, and in what conditions. In the territories where physicians, organizations, and regulatory authorities are educated, open, and responsive, the harm can be reduced almost to zero; on the contrary, in other places, the very same instrument causes the

[11] Carter v. Canada (Attorney General), 2015 SCC 5, 1 S.C.R. 331; Medical Assistance in Dying (MAID) legislation (Canada)

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most severe injustices.

2. Asymmetry in capacity- The current lack of palliative coverage, the overemphasis on clinical training in end-of-life care, and resource limitations have resulted in an unequal risk environment in India. Comparison-based evidence points to the risk of legalization turning into a source of additional suffering that is unnecessarily killed off if there is no adequate investment in palliative care, reporting mechanisms, and socio-legal protections.
3. The endorsement was conditional and from a supportive perspective only- The feedback indicated that a careful, conditional approach is to be taken India should not quickly legalize active euthanasia on a global basis. In fact, the change in policy should be gradual and dependent on the availability of clear legal definitions, strong procedural safeguards (capacity assessment, second opinion, reporting requirement), palliative infrastructure, and independent monitoring.

C. Practical, case-specific guidance

According to the review, active euthanasia should be legally and morally acceptable only if, by all evidences, the following are present:

- The patient is of sound mind and makes a fully informed, voluntary, and uncoerced request.
- The disease is medically unstoppable and brings about intolerable suffering even after the application of the best palliative treatment.
- A medical evaluation consisting of at least two doctors determines the prognosis and the voluntariness.
- The features of surveillance by the supervising body, the waiting period, and the recorded advance directives are in place.
- The social factors affecting the request (e.g., neglect, financial pressure) have been identified and reasonably addressed.

Nevertheless, a comprehensive prohibition of active euthanasia in cases where issues related to capacity, potential coercion, treatable illness with current therapy, and social deprivation are the underlying reasons for the request should be maintained.

The findings point one major lesson at the fore: euthanasia is not about law but stewardship. Cross-national data indicate that the supply of assisted dying is limited even where it is legally allowed; however, the legality shifts the responsibility to institutions and healthcare

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workers who need to interpret, implement, and control the practice. In India's case, the more prudent way is instrumentalism - first, palliative care and procedural mechanisms are to be strengthened; secondly, only after the systems and protections become reliable should narrowly defined, strictly regulated active-euthanasia be considered.

Discussion and Comparative Analysis

The euthanasia issue presents one of the most challenging dilemmas for both law and medicine — whether a right to live with dignity has to encompass a right to die with dignity. Modern medicine has raised life expectancy, but in most cases, it is a price paid through prolonged suffering without the possibility of recovery. The dilemma confronts societies with whether life has to be preserved at all costs and always remain humane.

At the global level, countries such as the Netherlands[12], Belgium, Luxembourg, Canada, Spain, Colombia, and New Zealand have adopted active euthanasia or assisted dying in closely controlled contexts. The Netherlands and Belgium, for example, involve clear patient consent and independent medical evaluation, with each case being reported to controlling authorities[13]. In Canada this legislation[14] brought about a model of medical assistance in dying under stringent protection like being authorized by medical practitioners and transparent process. All these experiences show that legalization is merely the beginning of the debate but not its culmination as only comprehensive regulation, accountability, and ongoing ethical discussion are initiated.

In India, however, the Supreme Court has reluctantly embraced passive euthanasia only in *Aruna Shanbaug v. Union of India (2011)* and later sanctioned living wills in *Common Cause v. Union of India (2018).* Active euthanasia is beyond the reaches of the courts and legislatures. The hesitation is owing to genuine concerns: poor healthcare centers, possibilities of abuse in a nation plagued by disparities, and insufficient robust medical regulatory systems.

At the same time, fear of abuse should not translate into blanket prohibition. The example of comparison illustrates that actual protection does not accrue from prohibition but from laid-

[12] The Lancet, "The euthanasia law in Belgium and the Netherlands", Vol. 362, Issue 9399, pp. 1239-1244.
[13] (*Terminations of Life on Request and Assisted Suicide Act, 2002)*Cambridge University Press, "Belgian Act on Euthanasia of 28 May 2002
[14] *Carter v. Canada (2015)*

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down procedures and regulation. For India, any model has to be context-specific — perhaps with independent medical boards, judicial review in exceptional cases, and transparent reporting — without offending cultural sensitivities necessarily.

Challenges and Recommendations

The Indian debate regarding active euthanasia cannot be separated from the realities of its social and legal environment. Whilst comparative experience identifies that a controlled system can exist, India faces its own problems that must be confronted prior to reform.

Challenges

- **Healthcare Infrastructure** – Compared to nations with highly developed public healthcare systems, India has bad uneven access, under-equipped hospitals, and scant palliative care facilities. Legalizing euthanasia without enhancing healthcare could risk putting it into misuse as a cheap alternative to treatment.
- **Risk of Abuse** – In a nation where corruption, poor economic conditions, and social inequalities are deep-rooted, there is a risk that weak individuals, the elderly, and terminally ill patients are likely to be intimidated into consenting to euthanasia.
- **Cultural and Religious Values** – The Indian culture places supreme value on family decision-making as well as the respect for human life. Any such alteration needs to balance individual freedom with societal values.
- **True Legal Ambiguity** – Although passive euthanasia is recognized by the Supreme Court, there is no law, and hence it remains ambiguous in application. The challenge is to devise a compassionate, responsible plan that protects the vulnerable without breaching constitutional promises. Physicians are still unsure in their role, and patients are faced with procedural hurdles.

Recommendations

- **Transparent Legislative Framework** – India needs a legislative framework that creates eligibility, protection, and supervision for active euthanasia. The parameters can be terminal illness, intolerable suffering and informed consent. The consent of guardian or parent in case of a child.
- **Independent Oversight Commissions** – Medical boards or ethics committees must review each request so decisions are not left in the hands of doctors or relatives. The judiciary may be required to approve in exceptional cases based on the condition of the

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person asking for active euthanasia as emotions and life of an individual is involved.

- **Open Reporting** – There must be reporting and monitoring by an independent agency following the model of the Dutch and Belgian systems to ensure accountability.
- **Investment in Palliative Care** – Legal reform must be followed by increased palliative and hospice care so that euthanasia emerges as a last resort, and not a substitute for medical treatment.
- **Public Debate and Awareness** – Since cultural acceptance is necessary, reforms must go hand-in-hand with public debate, awareness campaigns, and medical training.

  All this, India must develop a prudent, situation-specific strategy. Borrowing ideas from other places while tailoring protections to Indian realities will make room for the introduction of euthanasia, if at all, to further dignity without compromising vulnerability.

Conclusion

The argument about active euthanasia is not as much as legalizing or prohibiting a deed, but more on a definition of dignity in the final act of human life. India has gradually embraced passive euthanasia and advance directives, but the failure of the legislature to reach a consensus on active euthanasia reflects an unwillingness to confront the realities of terminal suffering. The question is not if active euthanasia should be legalized in India, but how to word it so that it continues to be a guardian of dignity rather than a tool for tyranny.

The comparative experience of the Netherlands, Belgium, and New Zealand would suggest that legalization with strict conditions, doctor's supervision, and transparent reporting can coexist with constitutional values and public trust.

However, this is not a judicial and legislative duty alone for India but also that of doctors and patients who have direct contact with such decisions. A poorly structured or strict legal system can have devastating consequences; however, a balanced system built on the case approach can be both autonomous and accountable.

Lastly, the success of all reform will depend upon evident interpretation, solid safeguards, and sensitivity to culture. As law and medicine converge on questions of life and death, the guiding principle must remain: "*When interpretation rests in the right hands, law becomes not a weapon of destruction but a shield of dignity."*