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EUTHANASIA AND RIGHT TO LIFE: INDIAN CONSTITUTION AND GLOBAL PERSPECTIVE

AUTHORED BY - MEGHNA SAINI
LLM,
University School of Law, Rayat Bahra University, Mohali

CO-AUTHOR - RAHAT MARWAHA
Assistant Professor,
University School of Law, Rayat Bahra University of Mohali

ABSTRACT

The issue of euthanasia is one of the most sensitive and discussed topics today in the legal and constitutional sphere due to the close links between this subject and the value of human life, autonomy, medical ethics and the concept of dignity during the very end of life. The present study focuses on the concept of euthanasia along with passive euthanasia in the Indian context and the link between euthanasia and Article 21 of the Constitution of India. It examines whether the "right to life" existing in the Constitution also extends to the right to die with dignity in cases of terminal disease or irreversible suffering or permanent vegetative state.

The paper starts off by clarifying the definition, nature and various types of euthanasia, such as active, passive, voluntary, involuntary and non-voluntary euthanasia. It also examines the evolving trajectory of the Indian judiciary in tackling end-of-life issues in some of the significant cases such as P. Rathinam v. Union of India, Gian Kaur v. State of Punjab, Aruna Shanbaug v. Union of India and Common Cause v. Union of India. However, these judicial advances highlight how Article 21 has evolved from safeguarding mere existence to acknowledging dignity, autonomy and humane treatment as key aspects of life.

The research additionally carries out an comparative investigation of the legal strategies adopted around the globe to euthanasia and assisted dying in countries including the Netherlands, Belgium, Switzerland, Canada, USA, and the UK. The study brings up a comparison of the various legal protections and ethical issues that have been used in different jurisdictions, and how these balance the rights of the individual with the right to life.

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In addition, the paper explores the clash between the criminal law and mental health law in India with respect to suicide and euthanasia, in the light of the Mental Healthcare Act, 2017 and evolution of stance towards Section 309 IPC. It critically examines the arguments for and against euthanasia, exploring issues of human dignity, autonomy, abuse, moral issues and safeguarding vulnerable groups.

Based on the findings in the study, the author finds that passive euthanasia is not prohibited by constitutional morality, rather it would be an extension of the right to live with dignity as guaranteed by Article 21, provided that the regulation is carried out through strict legal and medical safeguard. In India, however, the absence of a comprehensive legislation and the problems of procedure, unawareness and inadequate palliative care are still presenting practical difficulties. Thus, the paper highlights the importance of a clear statutory Bill which contains elements that are both compassionate and respectful, honouring the dignity of medical practice and preventing misuse, and also ensures that end-of-life decisions are humane, transparent and constitutionally well-founded.

KEY WORDS: Euthanasia, Article 21, Right to life, Right to die with dignity, Passive Euthanasia, Active Euthanasia, Harish Rana Case, Usa, Uk, India, 309 IPC

❖ THE CONCEPT AND CONTOURS OF EUTHANASIA

● INTRODUCTION TO THE INTERPLAY OF LIFE, DEATH AND LAW

The relationship between life, death, and law becomes most complex and contentious when examined through the lens of euthanasia. While law traditionally exists to preserve life and prevent its unlawful termination, situations involving terminal illness, unbearable suffering, and loss of dignity challenge this foundational objective. Euthanasia, often understood as the intentional ending of life to relieve pain and suffering, places the legal system at the intersection of morality, medicine, and individual autonomy.

In the Indian constitutional framework, the right to life under Article 21 has been expansively interpreted to include the right to live with dignity. This raises a critical question: does the right to live with dignity also encompass the right to die with dignity? The legal response to this question has evolved over time, reflecting a gradual shift from a strictly preservationist

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approach to a more nuanced understanding of human dignity. The recognition of passive euthanasia by the Supreme Court marks a significant development, as it acknowledges that prolonging life through artificial means, in certain circumstances, may conflict with the very dignity the law seeks to protect.

The debate about euthanasia is a complex one, it's not just about the law, but also about what's right and wrong. We have to think about how important life is, and also about the freedom of the person who is sick. Doctors and the government have a say in this too. To find a balance, courts have allowed something called passive euthanasia, but only if it's done in a very controlled way. This way, they can make sure that people aren't taking advantage of the system, while still letting patients have a say in what happens to them at the end of their life.

It's a difficult decision, but the goal is to respect the patient's choice, while also making sure that everything is done fairly and safely.

Euthanasia is a crucial issue where the law has to balance its responsibility to protect life with the growing awareness of individual freedom and dignity. This delicate balance highlights the need for a thoughtful and well-regulated legal system that can address the complexities of human suffering while staying true to the fundamental principles of justice and humanity. The law must consider the nuances of human experience and the evolving understanding of what it means to live with dignity, in order to create a framework that is both compassionate and just. Ultimately, the goal is to find a balance that respects the autonomy of individuals while also protecting the inherent value of human life.

- **ETYMOLOGY AND MEANING OF EUTHANASIA**

The word “EUTHANASIA” comes from two Greek words, “eu” which means “good or easy” and “thanatos” which means “death”. Hence it means “good or easy death”. It is also known as “mercy killing”. It refers to act which shorten or terminate life painlessly in order to end suffering where there is no hope of recovery. It is the act of ending one’s life by a lethal injection or suspension of medical treatment. Encyclopedia of ‘Crime and Justice’, explains euthanasia as an act of death which will provide a relief from a distressing or intolerable condition of living.

According to the World Medical Association euthanasia means, “Deliberate and intentional

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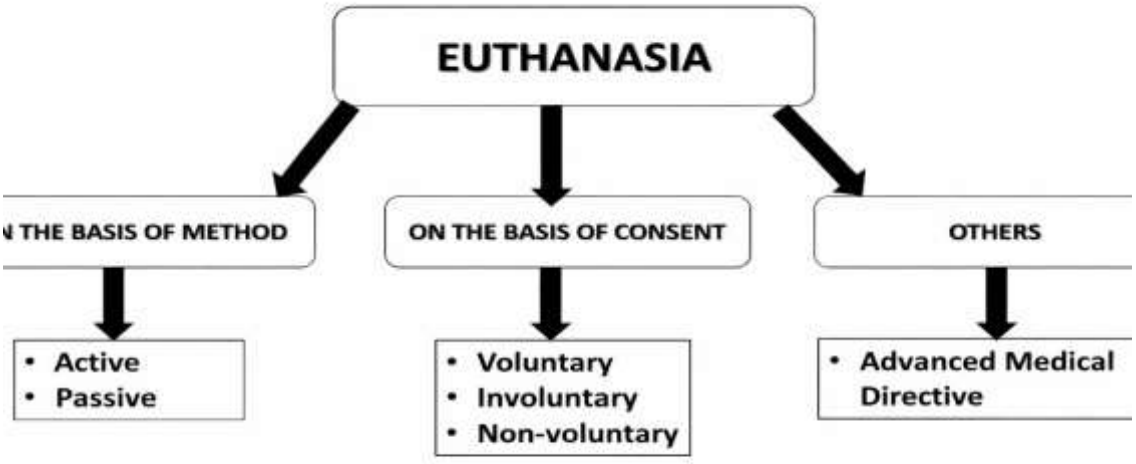
action with a clear intention to end another person's life under the following conditions:

- The subject is a competent informed person with incurable illness,
- Who voluntarily asked for ending his life,
- The person who is acting knows about the state of this person and about his wish to die and is doing this action with an intention to end life of this person,
- The action is done with compassion and without any personal profit"[1]

CLASSIFICATION OF EUTHANASIA

In order to understand the various kinds of Euthanasia, we must first understand the meaning



of the following terms:

- **Active or Positive**

Active euthanasia is a deliberate action to end the suffering of the patient and painlessly putting them to death for Merciful reasons. Here the euthanasia is practiced actively by the doctor administering lethal dose or medication to The patient. It is mostly found where the caretaker of the patient understands the suffering of the patient due to Incurable disease and out of their love decides to release the patient from misery. Active euthanasia is legally Prohibited as compared to Passive euthanasia depending on the situation and the case.

- **Passive or Negative**

Passive or Negative euthanasia is speeding up the death by changing in the level and form of support offered to the Patient. This is in the view of letting the nature take its course in the

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death of the patient. It is usually done by Removing the treatment that was sustaining the life of the patient and hence the patient dies as a result of it. It is Passive as in the doctor is not actively killing the person; they are simply passively not saving the patient. Simply Practiced by removing life supporting device such as respirator or ventilator, stopping medications and medical Procedures, removing the feeding tube, etc. Sometime, when the patient is declared critical with no hopes to Recover, the family members request the doctor to discharge the patient. The doctor discharges the patient on the Request of the family and the patient dies in few days. Some family are not in a position to afford treating the patient And hence taken out of the ventilator. This is termed as an omission to struggle rather than an act. Voluntary When the euthanasia is practiced directly with the consent of the patient on the request of the patient, it is called Voluntary euthanasia. It means the intentional administration of lethal drugs to terminate the pain suffered by the Patient, the pain which is incurable and unbearable by the patient, that means the termination of life is thoroughly Concerned on medical grounds. It is primarily concerned with the right of choice of the patient to end their life Which in turn is beneficial for them and everyone else. In voluntary euthanasia, it is necessary that the request to End the life should be made by the person himself suffering from intolerable pain or terminal illness. This request Should not be influenced or coerced by any family members or their caretakers around. The idea of voluntary Euthanasia is based on the principle of self-determination and right to self-autonomy which talks about value, worth, Respect, rights, freedom and decision making capacity. If an individual has decision making capacity, he also has the Right to take decision on how and when he shall die. Refusing voluntary euthanasia is a form of domination, as the Person is not respected for their views and being controlled by others. Voluntary euthanasia is also based on the Utilitarian principle. The purpose is to let the patient die peacefully and end the pain. It will be cruel to let people suffer The unbearable pain and hence the patient should be released of the pain. Though this act is legally wrong but Morally it is right.

- **Involuntary**

In Involuntary euthanasia, the patient is not in the condition to request for ending their life, here the patient's life is Brought to an end without their personal wishes or request. The motive is to release the patient from suffering pain And terminal illness but without any request or decision from the patient to end their life. This case is mostly when The patient loses all physical and mental functioning leaving only their biological body alive. Somewhere there is no Hope of recovery of the patient in this case. Involuntary euthanasia is also based on

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utilitarian principle, promoting Social welfare. This is only done when the person is incapable of making own decision. The aim is to provide social Benefits rather than more harm to the patient and caretakers around. The individual who is suffering from persistent Suffering and incurable disease and who wants to die but are unable to do so, they would be able to do it with the Assistance of a doctor injecting dosage of drugs, though there are various cases against doctor charging them for Murder or shortening the patient's life.

- **Non-Voluntary**

Non-Voluntary euthanasia is ending the life of a person who is not in the position to request or is not mentally Competent to take decision of ending his life. Hence it involves someone else to take decision for the patient whether To end the patient's life. This decision is mostly taken by their close family members. This is mostly done when the Patient is completely unconscious or incapable of doing anything and when the patient has left no wish to live or Given any further directions of living his life. It may be because of no opportunity to do so, or may have never Anticipated such accident in their life.[2]

❖ GLOBAL PERSPECTIVE ON THE RIGHT TO DIE AND EUTHANASIA

- **JURISDICTION PERMITTING ACTIVE EUTHANASIA AND ASSISTED SUICIDE:**

Country	Active Euthanasia	Passive Euthanasia	Assisted Suicide	Legal Safeguards
Netherlands	Yes	Yes	Yes	Informed Consent, Multiple doctors approval
Belgium	Yes	Yes	Yes	Consent, Medical Evaluation, Minors (Strict conditions)
Switzerland	No	No	Yes	Non-coercion, Patient autonomy
Canada	Yes	Yes	Yes	MAID law, Grievous and irremediable conditions
United States of America	No (Federal Govt)	Yes (Few States)	Yes	Strict procedural safeguards in Oregon, Washington & California

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In Netherlands, is the first country to come up with a legalisation on euthanasia, which evolved predominately through various judgments. The Postma case *(*1973*),* is a milestone because, for the first time, judges considered the possibility of impunity for termination of life on request. The court observed certain requirements to be met for termination of treatment. These were as follows:

- The patient is incurably ill because of a disease or an accident, or he is medically to be considered as such;
- The physical or mental suffering is subjectively unbearable or severe for the patient;
- The patient has expressed the wish to end his life or, in any case, to be relieved of his suffering, if need be in advance in writing;
- The euthanasia is performed by a physician: the attending physician or another in consultation with him.

Later in the case of **Schoonheim (1984)[3],** the Supreme Court considered that a physician can invoke Force Majeure in the sense of emergency if he;

- has carefully weighed the relevant duties and interests at stake,
- according to medical ethics and according to the medical-professional standard,
- and in doing so, and in view of the particular circumstances of the case, made an objectively justifiable choice.

The Supreme Court in the case also observed certain factors could be considered important for assessment. It is as follows:

- Whether, according to professional medical judgment, it was to be feared that the person would suffer increasingly from loss of dignity or that his suffering, already experienced as unbearable, would worsen;
- Whether it was foreseeable that he would soon be unable to die with dignity;
- Whether there were still possibilities to alleviate the suffering.

It is tempting to associate the first two factors with the principle of self-determination. Yet that would amount to an incorrect reading of the ruling. The Supreme Court did not discuss patient self-determination; it considered the aforementioned factors primarily as elements of suffering. The solution found in this case is clearly testimony of the doctors' perspective on the issue of euthanasia.

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In Chatbot (1994) case, the Supreme Court considered examination in person by a consultant essential. In addition, the Supreme Court also clarified the following points:

- The cause of suffering does not affect the degree to which it is experienced. In other words, the hopelessness and unbearability matter, not the cause (somatic, psychological or other);
- Suffering caused by a psychiatric illness or disorder can justify euthanasia as well;
- Psychiatric patients can also request euthanasia voluntarily and well-considered;
- In the event of such suffering, judges must assess the doctor's emergency with extra caution, because,
    1. it must be ruled out that the patient's decision-making ability was influenced by the illness or disorder, and
    2. both the severity and the hopelessness of suffering with such a cause are more difficult to establish;
- In principle, there is no hopeless suffering (i.e. without prospect of improvement) if the patient freely refuses realistic alternatives for relief.

Later, **in the Brongersma case (2002)[4]** Dr. A.H.J. Prins performed euthanasia on Senator Edward Brongersma, who was suffering from cancer. The court ruled that Prins was not guilty because he acted out of mercy. This case set a precedent for the decriminalization of euthanasia under certain conditions. Later the Brongersma Guidelines (1994) which was named after the aforementioned case, provided criteria for prosecuting physicians who performed euthanasia. They established that euthanasia would not be prosecuted if certain conditions were met, such as the presence of unbearable suffering and the involvement of a second physician. Further, the Termination of Life on Request and Assisted Suicide (Review Procedures) Act (2001) legalized euthanasia and physician-assisted suicide under strict conditions, making the Netherlands one of the first countries to do so. Assisted dying involves individuals who are terminally ill seeking medical assistance to obtain lethal drugs, which they then administer themselves to end their own lives.

Belgium legalized euthanasia through the **Belgian Euthanasia Act (2002),** allowing both voluntary and non-voluntary euthanasia in specific cases. Notably, Belgium permits euthanasia for minors under strict conditions, a provision absent in Indian law. While India's framework emphasizes judicial and medical scrutiny before allowing passive euthanasia, Belgium's law grants doctors significant discretion in performing euthanasia, provided ethical and medical guidelines are met. Belgium's approach is more progressive in recognizing euthanasia as a

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fundamental choice, whereas India remains hesitant to extend the right beyond passive euthanasia.

Luxembourg enacted Act on Euthanasia and Assisted Suicide in 2009. The law allows euthanasia for adults with irreversible suffering caused by a serious and incurable condition. Similar to Belgium and the Netherlands, there are stringent safeguards and requirements.

Switzerland, while euthanasia is illegal, the country permits assisted suicide under certain conditions. Organizations like Dignitas and Exit Switzerland provide assisted suicide services to terminally ill patients who meet specific criteria, such as having decision-making capacity and suffering from unbearable physical or mental distress.

Canada legalized medical assistance in dying (MAID) in 2016. The law allows eligible adults to request medical assistance to end their lives if they have a grievous and irremediable medical condition, are in an advanced state of irreversible decline, and experience enduring suffering that cannot be relieved in a manner acceptable to them. In Carter v. Canada (2015) SCC 5, where the Apex Court of Canada stated that Physician-assisted suicide shall be permitted in certain situations where the medical state of an individual is critical and irrecoverable. However, such consent should be provided by an adult in clear terms. The relevant para is extracted herein below: -

"[147] The appeal is allowed. We would issue the following declaration, which is suspended for 12 months:

Section 241(b) and s. 14 of the Criminal Code unjustifiably infringe s. 7 of the Charter and are of no force or effect to the extent that they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition."

Several States in the United States have legalized euthanasia or assisted dying under specific conditions. For example, Oregon's Death with Dignity Act (1997), Washington's Death with Dignity Act (2008), California's End of Life Option Act (2015), and others allow terminally ill patients to request medication to end their lives under strict regulatory frameworks.

The Supreme Court of United States in **Cruzan v. Director, MDH**[5] upheld the individual autonomy of the patients by ruling that the state would need to provide "clear and convincing evidence" of the individual's wish to end life assistance in order to persuade the doctor to do so. The relevant points mentioned by the court are;

- The court held that incompetent individuals retain a right to refuse treatment, which can be exercised by a surrogate decision maker using a "subjective" standard when clear

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evidence of the incompetent person's intent is present

- The court established that treatment could be terminated under a "limited-objective" standard if trustworthy evidence existed that the individual would have wanted to terminate treatment, but not enough to clearly establish their wishes for the subjective standard
- If no trustworthy evidence existed and a person's suffering would make the administration of life-sustaining treatment inhumane, a "pure-objective" standard could be used to terminate treatment
- The court rejected certain categorical distinctions drawn in prior refusal-of-treatment cases, such as distinctions between actively hastening death and passively allowing a person to die, treating individuals initially versus withdrawing treatment afterwards, and between different types of life-sustaining medical procedures
- Ultimately, the court emphasized that the decision to withdraw life-sustaining treatment should be based on the patient's expressed intent, with every effort made to minimize the opportunity for error, and that the record in the case lacked the clear and convincing evidence of the patient's intent to withhold life-sustaining treatment

Finally, Spain and France have debated euthanasia laws in recent years. Spain legalized euthanasia in 2021, granting terminally ill patients the right to die with medical assistance. France is currently considering similar legislation. Compared to India, Spain's model offers a more progressive approach, allowing voluntary euthanasia under regulated conditions, whereas India continues to emphasize passive euthanasia with strict judicial oversight.[6]

• JURISDICTION PERMITTING ONLY PASSIVE EUTHANASIA:

The United Kingdom allows passive euthanasia for patients in the Permanent Vegetative State (PSV). In Airedale National Health Service Trust v. Bland[7], the case was dealt with the removal of life supporting devices which can help in extension of life. The relevant points are mentioned below:-

- The court held that it was lawful to discontinue all life-sustaining treatment and medical support measures for the patient, Tony Bland, who was in a persistent vegetative state (PVS) with no hope of recovery.
- The decision was based on the best interests of the patient and the principle that the preservation of life is not an absolute value, especially when prolonging life would

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result in pain and suffering without any prospect of improvement.

- The court emphasized the importance of seeking the approval of the court in cases where there is a division of opinion among family members or responsible medical practitioners, ensuring a thorough investigation of all facts and circumstances.
- While recognizing the sanctity of human life, the court balanced this with the principle of self-determination and the quality of life, highlighting the need to consider wider factors beyond just pain when making end-of-life decisions.
- The judgment underscored the distinction between withholding or withdrawing treatment, which may be lawful in certain circumstances, and actively causing a patient's death, emphasizing the need for a legal framework that respects the dignity and humanity of patients in such critical situations.

Laws about euthanasia in the **USA** are different in each state. Death with Dignity laws have been passed in states including Oregon, Washington, and California. These laws allow doctors to help people die with stringent medical protections. In India, passive euthanasia requires court approval. In the U.S., however, states with euthanasia legislation provide terminally ill individuals the right to make their own decisions while making sure that healthcare providers follow the rules. But euthanasia is still illegal in many states, which makes the U.S. a mixed jurisdiction where regulations are very different from state to state. India's centralised judicial norms make sure that things are the same all over the country, while the U.S. has a decentralised approach.

India permits passive euthanasia under limited and carefully regulated circumstances as an aspect of the right to live with dignity under Article 21 of the Constitution of India. The jurisprudential foundation of this principle can be traced to the landmark case of Gian Kaur v. State of Punjab, where the Supreme Court of India held that the “right to life” does not include the right to die, but recognized that the right to live with dignity may include a dignified process of dying in cases of terminal illness. This principle was further developed in Aruna Shanbaug v. Union of India, where the Court for the first time allowed passive euthanasia under strict guidelines, permitting withdrawal or withholding of life-sustaining treatment for patients in a permanent vegetative state, subject to approval by the High Court and based on medical expert opinion. The legal position was significantly clarified and strengthened in Common Cause v. Union of India, where the Court unequivocally recognized passive euthanasia as lawful and affirmed the validity of living wills or advance directives, thereby allowing individuals to decide in advance that they should not be subjected to life-prolonging

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treatment in situations where recovery is not possible. Additionally, earlier observations in P. Rathinam v. Union of India, though later overruled, contributed to the broader debate on the autonomy of individuals in matters of life and death. Collectively, these judicial pronouncements establish that while active euthanasia remains illegal in India, passive euthanasia is legally permissible under strict safeguards, ensuring that the decision respects the patient's dignity, autonomy, and best interests, while also preventing misuse.[8]

● INTERNATIONAL HUMAN RIGHTS LAW AND THE RIGHT TO DIE WITH DIGNITY:

● A Right to Die *vis a vis* the Right to Life

While international human rights treaties have not established a "right to die", many contain explicit protections of the right to life. Under international human rights law, the right to life creates both negative and positive obligations for States. In other words, States must not only refrain from taking actions that violate the right to life, but also act affirmatively to create conditions necessary to protect that right.

Experts have debated whether the right to life could be interpreted as including a "right to end life." However, the European Court of Human Rights (ECHR) – the only human rights court to have adjudicated this issue – held that the European Convention on Human Rights' right to life "…cannot, without a distortion of language, be interpreted as conferring the diametrically opposite right, namely a right to die." Nor does the right to life, according to the ECHR, "create a right to self-determination in the sense of conferring on an individual the entitlement to choose death rather than life."

The Human Rights Committee (HRC), which monitors the implementation the International Covenant on Civil and Political Rights, has expressed similar concerns in its concluding observations to States that permit euthanasia. The HRC, for example, expressed its concern at the extent of euthanasia and assisted suicides in the Netherlands and urged "that this legislation be reviewed in light of the Covenant's recognition of the right to life.

● Right to Die *vis a vis* Other Human Rights

Other international human rights standards could be interpreted to provide for a "right to die", such as dignity, privacy, and autonomy, among others. Yet the Parliamentary Assembly of the Council of Europe recommends that states "respect and protect the dignity of terminally ill or dying persons in all respects" by upholding prohibitions against intentionally taking the life of

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people who are terminally ill or dying.

Conversely, bioethicists have expressed support for the establishment of a right to a dignified death. UNESCO's Universal Declaration on Bioethics and Human Rights (UDBHR) codifies both principles autonomy and dignity (Articles 5 and 10, respectively), and some bioethics scholars have relied on either or both of these principles to defend a right to a dignified death. As more and more countries begin to revisit and, in some cases, repeal their prohibitions on PAS and/or euthanasia, the international human rights community may need to reconsider its stance on a right to die with dignity.[9]

❖ PASSIVE EUTHANASIA IN INDIA & ARTICLE 21 OF CONSTITUTION OF INDIA

● THE EXPANSION OF ARTICLE 21: FROM MERE EXISTENCE TO LIVING WITH DIGNITY:

Article 21[10] states that "No person shall be deprived of his life or personal liberty except according to the procedure established by law." Therefore, Article 21 provides two primary rights: (1) Right to Life. (2) Right to Personal Liberty. Even though it is one of the greatest significant fundamental rights, as per other rights, this Right is not absolute and, apart from safeguarding the fundamental human rights, Article 21 provides for the reasonable restrictions on the same by way of procedure established by law, as to avoid the situations of ambiguity in the society. Right to life is vital to our very survival without which we cannot exist as a human being and encompasses all those perspectives of life, which go to conceive a man's life as essential, Comprehensive, and worth living. It is the only Article in the Constitution that has undergone The broadest permissible interpretations. It also includes the Right to shelter, growth, and nourishment. It is so because, it is the bare necessity, least and primary requirements that are Indispensable and unavoidable for a person for the Right to life and other rights. In Munn Vs. Illinois, Field J. observed that the term "life" as here used something more is meant than mere animal existence.

● THE EXPANDING AMBIT OF ARTICLE 21

The ambit of Article 21 has extended over the years through judicial precedents. The expansion of this Article is like a journey started with the case of A.K. Gopalan[11] and is twisting its way, Back from the Maneka Gandhi[12] case till today. The Apex Court held in A.K. Gopalan case (1950)14 that the contents and subject material of Article 21 and 19 (1) (d) are not alike, and

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they progress on total principles. In this case, the Word deprivation was interpreted in a narrow sense, and it was held that the denial does not restrict upon the Right to move freely which came under Article 19 (1) (d). The SC held that The expression 'procedure established by law' in the Constitution had embodied the British Concept rather than the American 'due process'.But the Maneka Gandhi case reversed the Gopalan decision. Here, S.C. stated that Articles 19 has a broad Scope including many rights, some of which are embodied under Article 19, thus giving them 'additional protection'. The Court also held that a law that comes under Article 21 must satisfy The requirements under Article 19 as well. That means any procedure under the law for the Deprivation of life or liberty of a person must not be unfair, unreasonable or arbitrary.With the advent of time, Article 21 has been interpreted in such a liberal sense that now, it Includes certain more rights, which helps a person to live such as the Right to live with dignity, Right to sleep, right to die, and many more.

Some of those rights are:

- RIGHT TO LIVE WITH DIGNITY

It is not sufficient to guarantee that a person has a Right to Live. An indispensable component Of life is one's honour and respect. Therefore, each person has ensured the right to live with Dignity – which implies having access to the requirements of human life as well as possessing Sovereignty over one's individual decisions. In Occupational Health and Safety Association v. Union of India[13], the assurance of Health and strength of workers and their access to just and benign circumstances of work were Taken as ideal conditions to live with human dignity. Moreover, as can be witnessed, human dignity is not a straightjacket approach. Instead, it Includes those rights and freedoms which permit a person to live life without infringement upon His or her self-respect, dignity and safety. As per Article 21, every person, whether a male, Female or member of the LGBTQ category, has a right to live with dignity. Therefore, The Court, in the case of Navtej Singh Johar v. Union of India[14] implementing the belief of Personal satisfaction, declared that Section 377 of the IPC was contradictory to Articles 14, 15, 19, and 21 of the Constitution of India to the degree that it forbids consensual physical acts of Adults in private. Hence, sexual acts among LGBT adults administered with the free assent of The parties included were certified legal.

- RIGHT TO DIE

The Right to Life bestows upon the person the right to live a full life and dictates that the State Cannot intervene in this Right besides through procedure established by law. But what if a

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Person wishes to end his own life? Can he intervene in his Right to Life? Section 309 of the IPC forbids attempt to suicide, with the condemned person meeting up to One year of imprisonment, or a fine, or both. Section 306, criminalizes abetment to suicide, i.e., the assistance given by a person in the Process of the commitment of suicide by another. But in the case of P. Rathinam v. Union of India[15], Managing Article 21 as well as the Principles of natural justice in remembrance, the two-judge bench ordered that Right to Life Also covered the Right not to live a restricted life Accordingly, Section 309 of the Indian Penal Code was held void.that Section 306, criminalizing abetment to suicide, was Constitutional as well. The Court Decided that suicide being an abnormal termination of life, it was against the concept of Right To Life But, the Court then reversed its position in the succeeding case of Smt. Gian Kaur v. the State Of Punjab[16], where, it was regarded that Section 309 of the IPC was constitutional as well. The Court Decided that suicide being an abnormal termination of life, it was against the concept of Right To Life.[17]

- **THE DEBATE ON RIGHT TO COMMMIT SUICIDE: ANALYSIS OF SECTION 108 OF BNS (FORMARLY 309 IPC) AND THE MENTAL HEALTHCARE ACT, 2017:**

According to Article 21 of the Indian constitution, "No person shall be deprived of his life or personal liberty except according to procedure established by the law". While the constitution covers the right to life or liberty, it does not include the 'right to die'. The attempts at taking one's own life are not considered to fall under purview of constitutional right to life.

Section 309 of the Indian Penal Code (IPC) clearly states as follows: "*Whoever attempts to commit suicide and does any act towards the commission of such offence, shall be punished with simple imprisonment for a term which may extend to one year or with fine or both.*"[18]

Several questions are raised in the context of section 309. First, it comes under the category of crimes defined under Chapter XVI of Indian penal code. All other crimes in this category include those committed to the 'human body of the other person' and suicidal attempt is clubbed with them in same category of crimes. The act of attempted suicide is inferred on basis of intention, which is inferred from circumstances. But the intention may be unclear or ambiguous in many cases. Further, the question of legal treatment of attempted suicide as a crime against state does not find many takers.

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The act of taking one's life was much abhorred by society in general and religious edicts in particular. However, with time, there has been a shift in the social perception of suicide. The act has been perceived as a result of the culmination of severe psychological trauma and distress thereby gaining increasing empathy in society. Within the Indian context, the demands to decriminalise attempt to commit suicide have grown over a period of time. The Law Commission too in its 42nd and 210th Reports advocated the humanisation of the attempt to commit suicide. Even the constitutional courts of the country have resonated with the same sentiment in a catena of cases.[19]

In P. Rathinam[20], the Supreme Court while discussing the constitutional validity of Section 309 remarked,. … It is a cruel and irrational provision, and it may result in punishing a person again (doubly) who has suffered agony and would be undergoing ignominy because of his failure to commit suicide. Then an act of suicide cannot be said to be against religion, morality or public policy, and an act of attempted suicide has no baneful effect on society. Further, suicide or attempt to commit it causes no harm to others, because of which the State's interference with the personal liberty of the persons concerned is not called for.

However, it was only in the year 2017 the Government took cognizance of this situation and tried to introduce a reform vis-à-vis Section 115 of the Mental Healthcare Act (the Act). Though the step taken by the Government is laudable on the count that it has formally acknowledged the fact that to prosecute and punish a person who is already distressed is inhumane.

The Mental Healthcare Act, 2017 represents a transformative shift in India's suicide laws by moving away from a punitive approach toward a humane, rights-based framework grounded in Article 21 of the Constitution of India. Traditionally, attempted suicide was criminalized under Section 309 of the Indian Penal Code, reflecting a legal stance that treated such acts as offences deserving punishment. However, the 2017 Act effectively overrides this approach by presuming that any person who attempts suicide is under severe stress and therefore should not be prosecuted, unless proven otherwise. This creates a strong legal safeguard against criminal liability and instead imposes a duty on the State to provide care, treatment, and rehabilitation to such individuals. From a legal analysis perspective, this marks a significant convergence between mental health law and criminal law, aligning the legal system with modern psychiatric understanding and human rights standards. It also reflects judicial reasoning seen in cases like Gian Kaur v. State of Punjab[21], where the Supreme Court of India acknowledged the need to treat the issue of suicide with sensitivity. Thus, while Section 309 has not been formally

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repealed, its practical application has been substantially diluted, signaling a paradigm shift from criminalization to compassion in India's legal treatment of suicide.[22]

- **MARUTI SHRIPATI DUBAL V. STATE OF MAHARASHTRA TO GIAN KAUR V. STATE OF PUNJAB: THE REJECTION OF THE RIGHT TO DIE:**

In Maruti Shripati Dubal v. State of Maharashtra[23], the Bombay High Court held that section 309, IPC is ultra vires the Constitution being violative of Articles 14 and 21 thereof and must be struck down. It was pointed out that the fundamental rights have their positive as well as negative aspects. For example, the freedom of speech and expression includes freedom not to speak and to remain silent. The freedom of association and movement likewise includes the freedom not to join any association or to move anywhere.

The freedom of business and occupation includes freedom not to do business and to close down the existing business. If this is so, logically it must follow that right to live as recognized by Article 21 of the Constitution will include also a right not to live or not to be forced to live. To put it positively, Article 21 would include a right to die, or to terminate one's life. The Court further pointed out that the language of section 309, IPC is sweeping in its nature. It does not define suicide. In fact, philosophers, moralists and sociologists are not agreed upon what constitutes suicide.

What may be considered suicide in one community may not be considered so in another community and the different acts, though suicidal, may be described differently in different circumstances and at different times in the same community. While some suicides are eulogized, others are condemned. That is why perhaps wisely no attempt has been made by the legislature to define either.

The want of a plausible definition itself makes the provisions of section 309 arbitrary and Violative of Article 14.There are different mental, physical and social causes which may lead different individuals to attempt to commit suicide for different ends and purposes, there being nothing in common between them. Section 309 makes no distinction between them and treats them alike, making the provisions thereof arbitrary.

Further, the Court observed that if the purpose of the punishment for attempted suicide is to prevent the prospective suicides by deterrence, the same is not achieved by punishing those who have made the attempts, as no deterrence is going to hold back those who want to die for

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a social or political cause or to leave the world either because of the loss of interest in life or for self-deliverance. The provisions of section 309 are unreasonable and arbitrary on this account also. As is rightly said, arbitrariness and equality are enemies of each other. The blanket prohibition on the right to die on pain of penalty, it was pointed out, is not reasonable.
The High Court also observed that there is nothing unnatural about the desire to die and hence the right to die. The means adopted for ending one's life may be unnatural varying from starvation to strangulation. But, the desire which leads one to resort to the means is not unnatural. Suicide or an attempt to commit suicide is not a feature of a normal life. It is an incident of abnormality or of an extraordinary situation or of an uncommon trait of personality. Abnormality and uncommonality are not unnatural merely because they are exceptional.

The High Court further observed that the right to die or to end one's life is not something new or unknown to civilization. Some religions like Hindu and Jain have approved of the practice of ending one's life by one's own act in certain circumstances while condemning it in other circumstances. The attitude of Buddhism has been ambiguous though it has encouraged suicide under certain circumstances such as in the service of religion and country. Neither the old nor the new Testament has condemned suicide explicitly. However, Christianity has condemned suicide as a form of murder. In contrast, the Quran has declared it a crime worse than homicide.
The High Court quoted the eminent French sociologist, Emile Durkheim's threefold classification of suicides made on the basis of the disturbance in the relationship between society and the individual:

i. Egoistic suicide which results when abnormal individualism weakens society's control over him; the individual in such cases lacks concern for the community with which he is inadequately involved;
ii. Altruistic suicide which is due to an excessive sense of duty to community; and
iii. Anomic suicide which is due to society's failure to control and regulate the behaviour of individuals.

This classification is not regarded as adequate by many, but gives us the broad causative factors of suicide. It is estimated that about onethird of the people who kill themselves have been found to have been suffering from mental illness.
The Court observed that those who make the suicide attempt on account of the mental disorders require psychiatric treatment and not confinement in the prison cells where their condition is bound to worsen leading to further mental derangement. Those on the other hand who make the suicide attempt on account of acute physical ailments, incurable diseases, torture or decrepit

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physical state induced by old age or disablement need nursing homes and not prisons to prevent them from making the attempts again.

In P. Rathinam v. Union of India,[24] a Division Bench of the Supreme Court also held that section 309, IPC violates Article 21, as the right to live of which the said Article speaks of can be said to bring in its trail the right not to live a forced life. Quoting from a lecture of Harvard University Professor of Law and Psychiatry, Alan A Stone, the Supreme Court noted that right to die inevitably leads to the right to commit suicide. However, the Supreme Court disagreed with the view of the Bombay High Court that section 309 is also violative of Article 14.

Dealing with the argument relating to the want of a plausible definition of suicide, the Supreme Court observed that irrespective of the differences as to what constitutes suicide, suicide is capable of a broad definition and that there is no doubt that it is intentional taking of one's life, as stated at page 1521 of Encyclopaedia of Crime and Justice, Volume IV, 1983 Edn.

As for the reason that section 309 treats all attempts to commit suicide by the same measure without regard to the circumstances in which attempts are made, the Supreme Court held that this also cannot make the said section as violative of Article 14, inasmuch as the nature, gravity and extent of attempt may be taken care of by tailoring the sentence appropriately; in certain cases, even Probation of Offenders Act can be pressed into service, whose section 12 enables the court to ensure that no stigma or disqualification is attached to such a person.

The Supreme Court observed that suicide, the intentional taking of one's life has probably been a part of human behaviour since prehistory. Various social forces, like the economy, religion and socio-economic status are responsible for suicides. There are various theories of suicide, to wit, sociological, psychological, biochemical and environmental. Suicide knows no barrier of race, religion, caste, age or sex. There is secularization of suicide.

The Supreme Court further observed that suicide is a psychiatric problem and not a manifestation of criminal instinct. What is needed to take care of suicide-prone persons are soft words and wise counseling (of a psychiatrist), and not stony dealing by a jailor following harsh treatment meted out by a heartless prosecutor. It is a matter of extreme doubt whether by booking a person who has attempted to commit suicide to trial, suicides can be taken care of.

The Supreme Court expressed the view that section 309 of the Penal Code deserves to be effaced from the statute book to humanize our penal laws. It is a cruel and irrational provision, as it may result in punishing a person again (doubly) who has suffered agony and would be undergoing ignominy because of his failure to commit suicide. An act of suicide cannot be said to be against religion, morality or public policy, and an act of attempted suicide has no

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baneful effect on society. Further, suicide or attempt to commit it causes no harm to others, because of which State's interference with the personal liberty of the concerned persons is not called for.

The Supreme Court also observed that the view taken by it would advance not only the cause of humanization, which is a need of the day, but of globalization also, as by effacing section 309, we would be attuning this part of our criminal law to the global wavelength.

In Gian Kaur v. State of Punjab,[25] however, a Constitution Bench of the Supreme Court overruled the decisions in Maruti Shripati Dubal and P. Rathinam, holding that Article 21 cannot be construed to include within it the 'right to die' as a part of the fundamental right guaranteed therein, and therefore, it cannot be said that section 309, IPC is violative of Article 21. It was observed that when a man commits suicide he has to undertake certain positive overt acts and the genesis of those acts cannot be traced to, or be included within the protection of the 'right to life' under Article 21.

'Right to life' is a natural right embodied in Article 21 but suicide is an unnatural termination or extinction of life and, therefore, incompatible and inconsistent with the concept of 'right to life'. The comparison with other rights, such as the right to 'freedom of speech', etc., is inapposite. To give meaning and content to the word 'life' in Article 21, it has been construed as life with human dignity. Any aspect of life which makes it dignified may be read into it but not that which extinguishes it and is, therefore, inconsistent with the continued existence of life resulting in effacing the right itself. The 'right to die', if any, is inherently inconsistent with the 'right to life', as is death with life.[26]

- **RECENT TREND ASSOCIATED WITH EUTHANASIA:**

Despite the Common Cause guidelines, families often faced insurmountable legal hurdles. Harish Rana's family first approached the Delhi High Court in 2024, but their plea was rejected because Harish was not on a mechanical ventilator. The High Court reasoned that since he was only receiving nutrition through a feeding tube, withdrawing that tube would constitute "starvation"—an act of active euthanasia.

The Supreme Court's 2026 judgment corrected this narrow interpretation. The Court decisively ruled that Clinically Assisted Nutrition and Hydration (CANH)—such as PEG tubes or nasogastric tubes—is a medical treatment, not just basic nursing care. Because CANH is a medical intervention requiring clinical assessment and management, it can be lawfully withdrawn if it no longer serves a therapeutic purpose and merely prolongs a vegetative existence.

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Procedural Safeguards and the "Best Interests" Test The new judgment emphasizes that the withdrawal of treatment must never be an "act of abandonment". Instead, it must be governed by the "best interests of the patient" principle. This test does not ask if it is in the patient's interest to die, but rather if it is in their interest to continue life-sustaining treatment that offers no hope of recovery.

To prevent misuse, the Court reiterated a streamlined two-tier medical review process:

Primary Medical Board: A team of experts at the treating hospital must certify the condition as irreversible.

Secondary Medical Board: An independent board, including experts nominated by the Chief Medical Officer, must concur with the primary board's findings.

If both boards agree that recovery is impossible and the family provides written consent, the treatment may be withdrawn without further court intervention.

Integration with Palliative Care

A critical contribution of the Harish Rana verdict is the mandatory link between the withdrawal of life support and palliative care. The Court directed that Harish be moved to an AIIMS palliative care center to ensure a "structured and clearly articulated withdrawal". This ensures that the patient does not experience pain or distress during the transition, fulfilling the constitutional mandate to protect the patient's dignity until their final moment.

Position on Section 309 and 306 of IPC

The Court's position in the Harish Rana case reinforces that the withdrawal of futile medical treatment for a patient in a Persistent Vegetative State (PVS) does not constitute an attempt to suicide under Section 309 and 306 of IPC, nor does it amount to abetment of suicide under Section 309 and 306 of IPC. While Section 309 and 306 of IPC has been effectively "neutralized" for individuals under "severe stress" by Section 115 of the Mental Healthcare Act, 2017, the Harish Rana judgment ensures that medical practitioners and family members are also protected from criminal liability when following the Court-mandated procedure. In contrast, active euthanasia remains legally impermissible and would constitute a penal offense under existing laws, including Sections 306 and 309 of the IPC, unless a specific statute is enacted by Parliament to permit it.[27]

❖ ARGUMENTS, COUNTERPOINTS AND THE WAY FORWARD

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- **ARGUMENTS IN FAVOUR OF EUTHANASIA:**

o Right to self-determination and autonomy:

A central argument in favour is that every individual should have control over their own body and medical choices. If a competent person can refuse surgery, ventilation, or other treatment, the law should also respect a reasoned decision not to continue futile life-sustaining intervention. For instance, in Common Cause (2018), the Supreme Court recognized that a person of sound mind may refuse treatment and may also execute an Advance Medical Directive (living will) for a future stage when decision-making capacity is lost.

o Right to die with dignity under Article 21:

Supporters argue that Article 21 protects not mere biological survival, but dignity, choice, privacy, and freedom from degrading treatment. Where treatment only prolongs irreversible suffering or vegetative existence, allowing its withdrawal may better reflect constitutional values than compulsory continuation. For instance, thE Supreme Court in Common Cause held that the right to live with dignity includes the right to die with dignity in terminal or irreversible conditions.

o Relief from unbearable and futile suffering:

Another strong argument is that medicine should not prolong agony when there is no realistic hope of recovery. In some cases, continued intervention becomes an extension of suffering rather than meaningful care. For instance, in Harish Rana (2026), the Supreme Court held that Clinically Assisted Nutrition and Hydration (CANH) is medical treatment and may be withdrawn where it no longer serves the patient's best interests and merely prolongs biological existence.

o Compassion and mercy:

The moral case for euthanasia, especially passive euthanasia, rests heavily on compassion. Where a patient is beyond recovery and enduring prolonged suffering, many argue that mercy lies not in indefinite intervention but in permitting a peaceful and medically supervised end- For instance, in Harish Rana, the Court stressed that withdrawal of treatment must be humane, must not amount to abandonment, and must be accompanied by proper palliative care.

o Preservation of human dignity in the final stage of life:

Supporters stress that no person should be forced to remain in a condition of total dependence,

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irreversible loss of consciousness, or extreme suffering when medicine offers no cure. A dignified death is seen as the final expression of a dignified life. For instance, the Supreme Court's end-of-life jurisprudence repeatedly links dignity with the patient's right not to be subjected to meaningless prolongation of treatment in hopeless cases.

o Reduction of emotional, physical, and financial burden on families:

Long-term end-of-life care can place enormous emotional, physical, and financial strain on families, especially where treatment continues for years without any prospect of recovery. For instance, in Harish Rana, the Court acknowledged the family's extraordinary devotion over more than a decade and recognized that allowing dignity at the end of life may itself be an act of love, not abandonment. Justice Pardiwala also warned that in the absence of a proper law, end-of-life decisions may be distorted by financial distress and socioeconomic vulnerability.

o Legal and ethical clarity for doctors:

Without a clear framework, doctors may continue futile treatment only out of fear of criminal liability, litigation, or accusation. A regulated system protects both patients and medical professionals by replacing informal bedside choices with legal safeguards.For instance, the Supreme Court framework and the Health Ministry's withdrawal-of-life-support guidelines rely on layered review through medical boards, consent, documentation, and judicial intimation.

o Respect for prior wishes through living wills:

A further argument in favour is that the law should honour a person's prior, clearly expressed wishes even after they lose capacity. A living will protects autonomy prospectively and reduces conflict among relatives and doctors. For instance, Common Cause (2018) recognized Advance Medical Directives, and the Supreme Court later simplified the procedure to make them more workable in practice.

o Avoidance of wasteful prolongation of non-beneficial treatment:

Some argue that in resource-constrained systems, keeping irreversibly ill patients on expensive life support indefinitely may consume scarce resources that could benefit others who have a realistic chance of recovery. This is not the main constitutional basis, but it is often raised in policy discussions. For instance, the Court itself has cautioned that financial hardship should never drive such decisions, which is precisely why strict safeguards are needed.

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o Comparative experience suggests regulation is possible:

Supporters often point to countries where euthanasia or assisted dying has been brought under structured legal control, arguing that abuse can be reduced through careful institutional design. For instance, Canada has a statutory framework for Medical Assistance in Dying, and jurisdictions such as the Netherlands regulate euthanasia through due-care criteria. Proponents use such examples to argue that end-of-life choices can be governed transparently rather than left to secrecy or arbitrariness.[28]

- **ARGUMENTS AGAINST EUTHANASIA:**

o Sanctity of life:

The most basic objection is that human life has intrinsic and inviolable worth. On this view, the law should never approve the intentional ending of life, even where suffering is severe. This concern is especially strong against active euthanasia, since it involves a direct act to cause death. For instance, in Gian Kaur case, the Supreme Court rejected a general right to die under Article 21, even though later cases recognized a narrower right to die with dignity in end-of-life situations.

o Slippery slope danger:

Opponents fear that once euthanasia is allowed for narrowly defined extreme cases, the categories may gradually expand to chronic illness, psychiatric suffering, minors, or socially vulnerable persons. For instance, critics often point to debates in countries such as Belgium and the Netherlands, where the legal scope has extended beyond the original terminal-illness model. This is used as a warning against normalizing intentional life-ending practices.

o Risk of abuse, coercion, and subtle pressure:

Another major objection is that vulnerable persons may feel pushed toward euthanasia by family fatigue, inheritance concerns, social neglect, or the feeling that they are a burden. In unequal societies, "choice" may be shaped by desperation rather than genuine autonomy.For instance, Justice Pardiwala in Harish Rana expressly warned that end-of-life decisions may be influenced by financial distress, lack of insurance, and socioeconomic vulnerability.

o True consent is difficult to verify:

Critics argue that it is often difficult to determine whether a person's request is fully informed,

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stable, voluntary, and free from depression, fear, or outside pressure. This becomes even harder where the patient lacks capacity and relatives or surrogates speak on the patient's behalf. For instance, the Indian framework requires multiple layers of medical review because consent alone is not seen as an adequate safeguard.

o Medical ethics and the Hippocratic tradition:

A long-standing objection is that doctors are healers, not agents of death. This concern is tied to the Hippocratic tradition, which has historically rejected the giving of deadly medicine. Critics argue that if physicians are empowered to end life, public trust in medicine may weaken. For instance, the World Medical Association remains firmly opposed to euthanasia and physician-assisted suicide, describing them as inconsistent with medical ethics and respect for human life.

o Palliative care is a better alternative:

Many opponents argue that the answer to suffering is not euthanasia but better palliative and hospice care. Good pain management, emotional support, and family counselling can significantly reduce end-of-life distress.

o Legal safeguards may fail in practice:

Even where the law is carefully framed, implementation can be inconsistent. Doctors may differ on prognosis, oversight bodies may be weak, and documentation may not capture coercion or hesitation. Because euthanasia is irreversible, even a small failure can have grave consequences. For this reason, Indian law has moved cautiously and still refuses active euthanasia while allowing only tightly regulated withdrawal of treatment.

o India's palliative care system remains inadequate:

This objection is especially strong in India, where access to palliative care remains uneven. Critics argue that euthanasia may become a substitute for care rather than a genuine autonomous choice made after all alternatives have been exhausted. For instance, official policy material recognizes palliative care as an important part of end-of-life care, yet access and implementation remain limited and uneven across the country.

o Possible devaluation of the lives of the disabled, elderly, and chronically ill:

Disability-rights and elder-rights critiques warn that euthanasia may send a harmful message

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that some lives are less worth living. The danger is that society my respond to suffering by eliminating the sufferer instead of improving support, inclusion, and care. This concern is especially relevant where disability, dependence, and old age are already stigmatized. Comparative debates in Europe and North America have made this argument more prominent.

o It may alter social attitudes toward suffering and care:

A broader objection is that normalizing euthanasia may gradually make society less patient, less caring, and less willing to invest in long-term support for the weak and dependent. Opponents argue that a humane society should respond to suffering by expanding care, not by facilitating death. This is why many critics accept palliative care and refusal of futile treatment, but oppose any move toward active euthanasia or physician-assisted suicide.[29]

- **WAY FORWARD**

Enact a comprehensive law on end-of-life care:

India should move from a judge-made framework to a clear statutory regime covering passive euthanasia, living wills, medical-board procedures, palliative care obligations, consent standards, and safeguards against misuse. For instance, in Harish Rana (2026), the Supreme Court itself urged the Centre to enact a comprehensive law on end-of-life care.

o Strengthen palliative and hospice care:

The right to die with dignity must not become a substitute for the right to receive proper pain relief, counselling, and end-of-life support. India needs wider access to palliative care in district hospitals, medical colleges, and community health systems. The Health Ministry's guidance also stresses that withdrawal of life support must be accompanied by humane palliative care.

o Simplify and popularise living wills:

Advance Medical Directives should be made easier to draft, register, and retrieve through secure digital systems, while preserving safeguards. Public awareness is still low, even though the Supreme Court has already recognized living wills and later simplified the process.

o Build robust medical-board capacity:

States should ensure ready panels of trained specialists so that decisions are timely, medically sound, and not delayed by lack of experts. Standard operating procedures should be uniform across hospitals to avoid arbitrary application. The Court in HarishRana also directed

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maintenance of updated district-level medical panels.

o Create strong oversight and grievance mechanisms:

A credible framework needs documentation, audit trails, reporting standards, and review mechanisms to prevent coercion, family pressure, or misuse. This is especially important in a society marked by financial vulnerability and unequal access to care.

o Train doctors, judges, and families in end-of-life ethics:

Medical professionals need training in prognosis, consent, communication, and palliative care. Families also need counselling support so that decisions are informed, humane, and less traumatic. This would help convert the constitutional principle of dignity into real practice.[30]

❖ CONCLUSION

The right to die with dignity is a complex issue that brings together constitutional law, human rights, ethics, and medical jurisprudence in a really important way. When we look at passive euthanasia, which is basically allowing someone to die naturally by not doing anything to prolong their life, it's not necessarily against the right to life. Instead, it's actually about respecting people's dignity, autonomy, and making sure they're treated humanely. As long as there are clear and transparent rules in place to make sure everything is done fairly and safely, passive euthanasia can be a way to uphold these important values. It's all about finding a balance between protecting life and respecting the wishes and dignity of individuals, especially when they're facing the end of their life. Article 21's dynamic interpretation has created constitutional space for recognizing that life's value lies not merely in biological continuation, but in the preservation of dignity and freedom from unnecessary suffering. Judicial recognition of passive euthanasia and living wills has marked a significant step toward humanizing Indian constitutional law. But even with the progress that's been made, there are still some big gaps in India's system, mainly because of a few key things: Absence of dedicated legislation, Procedural complexity, Limited public awareness, Medical implementation barriers and Ethical uncertainty.

The study therefore concludes that while passive euthanasia is a constitutional safeguard for dignified death, its effectiveness depends upon legislative clarity, medical preparedness, ethical oversight, and social acceptance. Ultimately, the challenge before India is to create a legal framework that simultaneously: Respects autonomy, Protects dignity, Prevents

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exploitation, Preserves ethical medical practice and Safeguards vulnerable populations..

A humane democracy must recognize that dignity is not limited to life alone, but extends to death. Therefore, a carefully regulated right to die with dignity should be understood as an essential component of constitutional compassion, human rights, and justice. In final analysis, passive euthanasia is not merely a legal doctrine but a reflection of society's commitment to balancing life, liberty, dignity, and humanity at the final stage of existence.

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