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MERCY KILLING: LEGAL, ETHICAL, MORAL PERSPECTIVE

AUTHORED BY - AREESHPERUMAL.M
LL.M Final Year Student (Criminal Law) Crescent law school
B.S Abdur Rahman Crescent Inst of Science and Tech, TN

Abstract

Mercy killing or euthanasia is one of the most controversial issues at the intersection of law, medicine, ethics and religion. This essay examines mercy killing from the legal, moral and ethical angles with special reference to India. The paper contends that active euthanasia remains illegal, while passive euthanasia has been legally permitted in several countries like India, citing judicial pronouncements, comparative study of laws and philosophical and religious justifications. The ethical debate revolves around opposing views on autonomy, the sanctity of life, and the proper role of medicine. It concludes, "Any legal framework must prioritize strong protections, as well as easily accessible palliative care and a cautious approach that protects vulnerable populations while upholding individual dignity.

Introduction

The modern term euthanasia refers to the deliberate, purposeful hastening of death so as to relieve a patient of intolerable pain. It is derived from the Greek words eu (good) and thanatos (death), literally "good death". The term mercy killing includes a range of actions from the active administration of lethal drugs at the patient's request, to the passive withholding of futile life sustaining treatment. Talk of mercy killing is not purely academic. It poses important questions about the value of human life, the limits of individual autonomy, the duties of doctors and the role of government in regulating life and death. Different societies have come to very different conclusions. India has permitted only passive euthanasia under strict judicial supervision. Whereas Netherlands and Belgium have legalized active euthanasia under controlled conditions. Religious traditions, especially Islam, Christianity and Judaism, have usually forbidden active euthanasia but have permitted the withdrawal of burdensome treatment. The essay is divided into three parts. It first looks at the legal framework allowing mercy killing with focus on India's cautious judicial advance and a comparative view of other

ISSN: 2582-6433

jurisdictions. Second, it examines the moral justifications for and against legalization in terms of the concepts of autonomy, beneficence, and non-maleficence. Third, it examines the development of cultural attitudes from the standpoint of morality and religion. The conclusion pulls these threads together and offers suggestions for a comprehensive strategy.

Legal Perspectives:

India's Constitutional Journey

India's legal position on euthanasia has been altered gradually by judicial interpretation rather than legislative adoption. In Gian Kaur v. State of Punjab (1996), the Supreme Court held that there is no "right to die" under the "right to life" guarantyd by Article 21 of the Constitution and thus, the law on preservation of life. This restrictive view prevailed until Aruna Ramachandra Shanbaug v. Union of India (2011) where the Court expressly rejected active euthanasia but allowed passive euthanasia in certain circumstances. In a first, the Court recognized that keeping a patient alive at all costs may not be in the best interests of the patient, by requiring High Court approval before discontinuing life support. [1]The judgment in Common Cause v. Union of India (2018) by a Constitution Bench that the "right to die with dignity" is part of the right to life under Article 21 was a game changer. It also upheld the validity of advance medical directives, commonly known as "living wills," by which people can decide in advance how they will be treated if they are unable to make decisions for themselves. In 2023, the ruling was again changed, when the Court made it easier to execute living wills, thus simplifying the procedure for patients nearing the end of their lives. More recently, a significant void in the body of precedent was filled by the Supreme Court's ruling in Harish Rana v. Union of India (2026). It concerned a 32-year-old man who had been in a permanent vegetative state for over a dozen years. In approving the withdrawal of life-sustaining treatment, the Court held that medically assisted nutrition and hydration are medical treatments, not basic care, and that withdrawal of such treatment is not equivalent to "starvation." The Court stressed that medical futility – where therapy has no therapeutic effect and only prolongs the dying process – is a legitimate concern and that dignity does not erode at the threshold of death. [1]Despite these advances, active euthanasia is still very much forbidden in India. In the case of Aruna Shanbaug, the Supreme Court has observed that while active euthanasia will continue to be prohibited, passive euthanasia is permitted only in exceptional circumstances. This difference is a reflection of a more fundamental principle: is the law allowing a natural medical condition

[1] *Gian Kaur v. State of Punjab*, (1996) 2 SCC 648 (Supreme Court of India).

ISSN: 2582-6433

to take its course, or is it provoking death?

Comparative Law Structures

The legal landscape for euthanasia is surprisingly varied around the world. Assisted suicide is legal in some form or another in seven European countries: Switzerland, the Netherlands, Belgium, Luxembourg, Austria, Spain and Portugal. Belgium reported 4,486 cases of euthanasia in 2025, a rise of 12.4% over the previous year. The Netherlands has indeed implemented legal safeguards, but has been criticized for its lack of transparency in supervisory processes.Switzerland allows assisted suicide, but only under very strict guidelines and there are concerns it could be abused. Physician-assisted suicide is legal in some states in the United States, including Oregon, where it has been practiced for about thirty years, since 1997. Under Oregon law, a terminally ill adult with a prognosis of six months or less has to be approved by two doctors to request deadly drugs. Oregon data show the most common reasons for requests are fear of being a burden (43%), loss of autonomy (89%) and loss of dignity (65%). Canada is a cautionary tale for the believers in the "slippery slope" theory. Medical assistance in dying (MAID) was introduced in 2016 for patients suffering from terminal illness but was broadened in 2021 to include anyone suffering from a "irreversible" disease that causes unbearable suffering. MAID represents about 1 in 20 deaths in Canada right now, while in Oregon it's closer to 1 in 100. [2]The Indian approach is compared to the more restrictive American model and the liberal European model. India has treaded cautiously, allowing only passive euthanasia in court rulings. This is a sign of a constitutional mindset that is very careful about the possibility of abuse and at the same time attaches a high value to the right to life.

"**India's Procedural Safeguards**"

The amended Common Cause rules, 2023 provide a multi-tiered procedure for implementation of advance instructions and passive euthanasia. The patient's condition is confirmed by a primary medical board. A secondary medical board concurs The decision is then communicated to the jurisdictional Judicial Magistrate of First Class. The magistrate will examine the patient and the medical records before giving the green light for implementation. If the medical boards deny approval, the executor or family members can move a writ petition in the High Court. These safeguards are burdensome, but they reveal the reluctance of the judiciary to act hastily.[1]

[2] Oregon Health Authority, *Oregon Death with Dignity Act Annual Reports*, Year 28 (2025),

ISSN: 2582-6433

Moral Positions:

The Principle of Autonomy

The strongest ethical case for mercy killing is respect for the autonomy of the individual. Liberal philosophers argue that competent people should have a choice about how and when they die, especially if they are suffering from a terminal illness. Ronald Dworkin, in his work on "reverence for life," argues that people who have different views about what makes a life worthwhile should not be forced to accept some particular view of what life is worth. Viewed in this light, the refusal to allow a terminally ill patient to choose a dignified death is a form of paternalism that does not recognize the patient's capacity to make his or her own choices. Data from countries that allow assisted suicide support the argument for autonomy. The vast majority of petitions in Oregon cite loss of autonomy rather than inadequate pain.management as the primary concern. This implies that the loss of agency, the ability to make meaningful decisions about one's own life, is often more important in the wish for death than physical pain.

The Principle of Non-Maleficence

Those opposed to mercy killing point to the non-maleficence principle, primum non nocere, or "first, do no harm," as a fundamental principle of medical ethics. The Hippocratic tradition also explicitly refuses to provide a lethal medication, even if requested. Opponents argue that legalizing physician-assisted suicide would mark a radical departure in the nature of medicine, transforming healers into killers and undermining public trust in the profession.

This is a more serious problem in societies with unequal access to health care. When assisted dying is an option the elderly, the disabled, the poor and other vulnerable patients may feel coerced into choosing death. They may do so because they don ' t want to be a burden on their families or the state. In the words of one blogger, in a country that cannot provide universal healthcare, the problem of abuse is not merely theoretical. The Canadian extension of MAID to non-terminal conditions is offered as one piece of evidence that the "slippery slope" is not an abstract concern, but rather an actual track.

The Argument from Conscience

Opponents of mercy killing state a more complex moral position based on what could be called the "argument from conscience" rather than the "sanctity of life" argument. The position holds that to reduce human life to something instrumental to something valuable only insofar as it is productive or pain-free or autonomous is to mistreat the inherent worth of the person. Life is not precious in the religious sense, but one should love and care for a dying person, and not

ISSN: 2582-6433

simply give him a hasty death. One philosopher, for example, contends that the argument from conscience is not built on impersonal ideals but on "love and attention for the dying." This view contradicts both sides of the argument. It dismisses both the rigid absolutism that would prolong life at all costs and the utilitarian calculus that would measure suffering against relief. Instead, it advocates a middle path of aggressive palliative care, emotional support and a rejection of the idea of death as a way to end suffering. [3]

Alternative to Palliative Care

A common theme in the literature is that if palliative care was more available and appropriately funded then the need for euthanasia would be lessened. The idea is simple: if their suffering, both psychological and physical, were properly addressed, fewer patients would attempt suicide. This position implies that the practical urgency of the problem is a function, in part, of deficiencies in the healthcare system, but does not resolve the ethical dilemma in principle. The Indian context is helpful here. The Supreme Court's acceptance of passive euthanasia has coincided with calls for better access to healthcare and palliative care facilities. The judiciary said the state must focus on saving lives and enhancing treatment, not on expanding the grounds for ending them. It has said passive euthanasia is acceptable, but only with strict medical and judicial supervision.

Religious and Ethical Viewpoints:

Islam View

In Islam suicide and voluntary euthanasia are strictly prohibited. The Quran directly prohibits "Nor kill (or destroy) yourselves: for verily Allah hath been to you Most Merciful". Life is considered a gift from Allah and humans are regarded as stewards, not proprietors of their lives. This is supported by the teachings of the Prophet Muhammad, with hadith warning that anyone who prevents their own death because they are impatient with suffering will not be allowed to enter Paradise. But Islamic law makes a clear distinction between the withdrawal of futile treatment and the deliberate taking of life. The Islamic Medical Association of North America (IMANA) disapproves of assisted suicide and euthanasia but permits the withholding or withdrawal of life-extending treatment if a panel of doctors determine death is inevitable. Mechanical support can be withdrawn and the patient allowed to die without unnecessary interventions. There is a pragmatic position that life is valuable, but there is no need to

[3] Medical ethics and non-maleficence

ISSN: 2582-6433

artificially prolong the dying process. [1]

Christian Perspectives

Christianity also frowns upon aggressive suicide. In a joint statement with the Chief Rabbinate of Israel, the Catholic Church said it rejected "the concept of active euthanasia (so-called mercy killing) and physician-assisted suicide, as the illegitimate human arrogation of an exclusive Divine authority to determine the time of a person's death." "Human life is sacred precisely because, as the Bible teaches, the human person is created in the Divine Image," it said. However, many Christian faiths generally accept passive euthanasia. Deliberately causing death is not the same as stopping or withholding burdensome treatment that offers no realistic hope of recovery. Pope Francis issued a warning against a sociocultural background that undermines the understanding of what makes human life sacred. At the same time he highlighted the significance of compassionate palliative care and making all efforts to lessen pain and suffering.[4]

Jewish Views

Jewish law has a similarly complicated position. The joint statement of the Holy See and the Chief Rabbinate of Israel distinguishes between acts of omission and acts which hasten death. Physician-assisted suicide and active euthanasia are illegal, but in some situations the discontinuation of ongoing medical care (e.g., a ventilator or pacemaker) and the discontinuation of therapies that merely prolong life beyond the point necessary for human survival are legal. While recognizing that not all that is physically possible is morally obligatory, the focus is on the sacredness of life and the rejection of human ownership of life.

The Indian Ethos

The Indian constitutional approach may be described as a fusion of these views. The Supreme Court has cautiously introduced the right to die with dignity in Article 21, limiting it to passive euthanasia and prescribing certain procedural safeguards. By invoking the Sanskrit subhashita—"Between the funeral fire and the mental worry, it is the mental worry which is more devastating"—the Court taps into an Indian sensibility: the perception that sustained suffering is a serious harm that the law cannot disregard for the patient and the family alike. But the prudence of the law implies a recognition that the power to take life is too dangerous

[4] Bible reference

ISSN: 2582-6433

to be used except with the most rigorous supervision.

Survey Data on Euthanasia

The most directly relevant data comes from a study assessing attitudes toward passive euthanasia among patients, families, and healthcare professionals. Note that this survey specifically addresses passive euthanasia (withdrawal of life support), which is legal in India, not active euthanasia, which remains illegal.

Chart 1: Attitude Toward Passive Euthanasia (All Respondents)

Category	Percentage
Support	77%
Neutral / Undecided	16%
Oppose	7%

Chart 2: Support for Euthanasia by Professional Group

Group	In Favour
Legal Fraternity	78%
Medical Fraternity	58%

Key Context and Caveats

- Passive vs. Active: The legal status in India is crucial. The Supreme Court legalized passive euthanasia (withdrawal of life support) in 2018, but active euthanasia (administering lethal medication) remains illegal and is treated as murder.
- Study Limitations: The 77% support figure comes from a specific study on terminal cancer cases and may not represent the entire Indian population. Other surveys among medical students and doctors show varying support levels, sometimes as high as 66% or 83%, depending on the specific group and question phrasing.
- No National Consensus: There is no single, nationwide survey that definitively captures the views of all Indians on this complex issue. The data above reflects the attitudes of specific surveyed populations and should be interpreted with that limitation in mind.

If you need data on a different aspect, such as awareness of advance directives or the reasons behind opposition, please let me know.

ISSN: 2582-6433

CONCLUTION:

The debate over mercy killing is difficult to resolve because it involves deeply held and legitimately conflicting ideals. Autonomy and dignity are in conflict with the obligation of care and the sanctity of life. The risk of abuse is balanced against the relief of suffering. The desire for a good death is at odds with the fear of a sudden fall.

This investigation yields three conclusions. The first is that the distinction between active and passive euthanasia provides a practical legal foundation, despite philosophical disagreement. India's approach is a reasonable middle ground, allowing the cessation of ineffective therapy, while prohibiting the active use of lethal drugs. It does affirm the right to a dignified death without going too far in the direction of intentional murder. The Harish Rana ruling was a major step forward in creating a more humane and coherent body of law, by confirming that scientifically assisted nutrition and hydration are medical treatments.

Second, it is essential to have procedural safeguards. The Indian model is hard work but necessary, requiring multiple certifications by medical boards and oversight by the judiciary. The experience of countries which have legalized assisted dying and especially Canada's extension beyond terminal illness demonstrates that there are real risks of abuse and that strong and ongoing safeguards are required. Given the glaring healthcare disparities and the fledgling nature of the palliative care landscape in India, it is not surprising that India is cautious. Third, the law cannot alone address the moral and ethical aspects of mercy killing. Cultural attitudes, philosophical debates and religious traditions will continue to inform people's responses to death and suffering. I think it is better to enhance the quality of life that is left rather than to extend the reasons to end life. There would be less desire for assisted suicide if we had better care for people nearing the end of life," one doctor noted.

The law is not there to settle moral disputes. It is there to protect the most vulnerable and to set boundaries within which people can make very personal decisions. India's present system is that active euthanasia is banned but passive euthanasia is allowed under close supervision. This is a fair balance. It acknowledges that death can be a mercy in some circumstances but insists that taking a life is always a matter of the utmost concern. In so doing it safeguards the sanctity of human life guarantyd by the Constitution and the dignity of the individual.