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BEYOND JUDICIAL PRECEDENT: THE URGENT NEED FOR CODIFIED LEGISLATION ON RIGHT TO DIE (EUTHANASIA) IN INDIA

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Abstract

This document examines the intricate legal, ethical, and medical facets of euthanasia, a complex concept that includes active, passive, voluntary, and non-voluntary forms. In India, the legal landscape surrounding end-of-life care has experienced substantial shifts, largely due to influential Supreme Court decisions. Although the judiciary has formally recognized passive euthanasia and legally validated "Living Wills" to safeguard an individual's constitutional entitlement to a dignified death, considerable legal ambiguity remains. Despite the Indian Law Commission's consistent and pressing advocacy for comprehensive legislation, the country continues to rely exclusively on judicial pronouncements to navigate these intricate ethical quandaries. This analysis, informed by international benchmarks, considers the primary arguments against legalization, including the potential for abuse and the critical necessity for improved and more readily available palliative care, thereby underscoring the pressing need for formal parliamentary law. Such legislation is crucial to establish explicit legal parameters, ensure uniform medical practices, and, ultimately, uphold human dignity.

Tag: Euthanasia, Passive Euthanasia, Right to Die with Dignity, Article 21, Right to Life

1. Introduction

The word "euthanasia" is derived from the Greek word "eu" and "thanatos", which mean "good death."¹ It is commonly described as mercy killing". According to the Senate Selection of Bills Committee, it can be classified into four primary categories based on the nature of the action and presence of patient consent. Active voluntary euthanasia involves a medical intervention

¹ Harris NM "The euthanasia debate" 147 (3) J R Army Med Corps 367-70 (2001).

carried out to end a life on the explicit request of the patient². Passive voluntary euthanasia is carried out when life-sustaining medical treatment is intentionally withheld or withdrawn on the patient's direct request³ and When these actions take place without the patient's consent due to the patient being incapacitated they may fall under non-voluntary classifications. Passive non-voluntary euthanasia involves the removal or withholding of medical treatment or life support without the patient's request on the other hand active non-voluntary euthanasia entails a direct medical intervention to end the patient's life without their explicit consent.

Prominent legal texts provide a clear frameworks for understanding this concept: Black's Law Dictionary⁴ defines euthanasia as the compassionate act of ending the life of an individual who is suffering from an incurable and painful disease or medical condition. The Encyclopedia of Crime and Justice⁵ characterizes it as action that brings about death specifically to grant a patient relief from a severely distressing.

Historically, the Indian Penal Code (IPC) treated both attempting and abetting suicide as criminal offenses, but the legal perspective has undergone significant shifts. In a landmark 1994 ruling, the Supreme Court struck down IPC Section 309, which penalized attempted suicide, declaring it unconstitutional under Article 21's Right to Life. However, this stance was challenged just two years later when individuals convicted of abetting suicide under IPC Section 306 argued that if Article 21 included a "right to die," assisting a suicide was merely helping someone exercise a fundamental right. This prompted the Constitution Bench to clarify the law reversing the 1994 position by ruling definitively that the Right to Life does not encompass the right to die and the Court established that attempting and abetting suicide are distinct offenses. Leaving the laws against abetment firmly intact. However, the Supreme Court acknowledged that individuals attempting suicide that are often experiencing severe depression and need psychiatric care rather than the punitive measures that leading to a strong recommendation that Parliament formally remove the penalization of suicide attempts.

² Cica N, "Euthanasia - The Australian Law in an International Context: Part 1: Passive Voluntary Euthanasia" 3 Parliamentary Research Service iv (1996-97).

³ The House of Lords Select Committee on Medical Ethics preferred to speak of "withdrawing or not initiating treatment" than using the term "passive euthanasia", arguing that there "is plenty of scope for argument over the ethical equivalence of killing and letting die in certain circumstances" House of Lords, 1 "Report of the Select Committee on Medical Ethics"

⁴ Black's Law Dictionary (8 th editon)

⁵ Encyclopedia of Crime and Justice (Vol. 2, pp. 145–150). Oxford University Press.

The historical statutory framework around issues primarily base this issue on IPC Sections 306 for abetment and 309 for attempted suicide and 304A for causing death by negligence. Recently, a major philosophical and legislative shift occurred with the introduction of the Bharatiya Nyaya Sanhita, 2023. Section 52 of this new code effectively decriminalizes suicide attempts and officially recognizing that individuals in acute mental distress need compassion and medical care rather than criminal prosecution. However these progressive reforms regarding mental health a profound legal ambiguity lingers concerning euthanasia. The Indian legal system should catch with whether voluntary or medically assisted dying can be distinctly separated from traditional definitions of suicide and betment, whether a patient's explicit and informed consent can ever serve as a valid legal defense for healthcare providers.

2. The Judicial Evolution of Euthanasia:

In *P. Rathinam v. Union of India*⁶ the petitioner had challenged constitutionality of Indian Penal code, Section 309 that criminalized attempted suicide. The Supreme Court drew direct parallel to other fundamental rights arguing that just as the freedom of speech (Article 19) includes the right to remain silent, the Right to Life (Article 21) inherently includes the right not to live. Thereafter, the Court temporarily struck down Section 309 as unconstitutional.

In *Gian Kaur v. State of Punjab*⁷ - five-judge Constitution Bench reviewed the conviction of a couple for abetting a suicide under IPC Section 306. The defense argued that if individuals possess a right to die assisting them is merely helping them exercise thier fundamental right.

However, The Supreme Court fundamentally disagreed overruled the *P. Rathinam* decision. The Bench ruled that Article 21 is a natural right to life and interpreting it to include the right to terminate that life is inherently contradictory. while upholding this laws against attempting and abetting suicide the Court implemented a crucial legal seed that is by acknowledging that "the right to die with dignity" could potentially intersect with the right to life in certain extreme circumstances.

The Breakthrough for Passive Euthanasia: *Aruna Ramachandra Shanbaug v. Union of India*⁸ officially introduced the concept of passive euthanasia to Indian jurisprudence. A petition was

⁶ *P. Rathinam vs. Union of India*, 1994(3) SCC 394

⁷ *Gian Kaur vs. State of Punjab*, 1996(2) SCC 648

⁸ *Aruna Ramchandra Shanbaug v. Union of India*, 2011

filed on behalf of Aruna Shanbaug who had existed in a Persistent Vegetative State (PVS) for decades following a brutal assault and seeking permission to withdraw her life support and feeding.

While the Court ultimately denied the request to withdraw Shanbaug's treatment, it also made a monumental legal leap by ruling that passive euthanasia is permissible in India under exceptionally and heavily monitored circumstances. The Court also laid down strict interim guidelines and the Court invoked the *Parens Patriae* principle (acting as the parent / guardian of the nation) asserting that the legal system is the ultimate decision maker for an incapacitated patient's best interests. Under Article 226 of the Constitution, High Courts were granted the authority to approve the withdrawal of life support.

The Procedure: Applications must be heard by a Bench of at least two Chief Justice-appointed judges. The Bench must consult an independent committee of three doctors (ideally a physician, psychiatrist, and neurologist) and hear from the patient's close relatives or next friend before issuing a verdict.

Legalizing the "Living Will": In *Common Cause v. Union of India*⁹ This definitive ruling firmly established the constitutional right to die with dignity. A public interest litigation sought legal backing for passive euthanasia and "Living Wills" (Advance Medical Directives).

A five-judge Constitution Bench unanimously ruled that the right to a dignified life under Article 21 extends to a dignified death. The judgment established advance Directives that individuals can legally execute a Living Will detailing their refusal of life prolonging treatments should they become comatose or terminally ill in the future and to prevent abuse these directives require strict validation including certification by a judicial magistrate and thorough review by specialized medical boards before any life support can be withdrawn.

The real-world application of the Common Cause guidelines was recently demonstrated in a compassionate ruling by a Division Bench (Justices J.B. Pardiwala and K.V. Viswanathan). Here, The Court permitted the withdrawal of Clinically Assisted Nutrition and Hydration (CANH) for a young man who had been in a PVS for 13 years. The court's ruling underscored

⁹ *Common Cause Society v. Union of India* (2018) 5 SCC 1.

the inseparable connection between a dignified death and access to quality palliative care. The judges insisted that the process of withdrawal be devoid of pain and suffering. They articulated a contemporary legal perspective on euthanasia, observing that the decision resides at the convergence of medicine, compassion, and love. This isn't about actively ending a life; it's about a compassionate choice to avoid extending suffering when life has naturally run its course.

Today, there is a robust international consensus that a terminally ill patient possesses a fundamental common law right to refuse modern life prolonging medical interventions and allowing nature to take its course. This principle of bodily autonomy had been consistently upheld by high courts across the globe. Some Notable landmark cases that illustrate this unified legal philosophy include:

In United Kingdom: Airedale NHS Trust v. Bland , United States: Cruzan v. Director, Missouri Department of Health (Supreme Court, 1990) Ireland: Re a Ward of Court (Supreme Court, 1995) Scotland: Law Hospital NHS Trust v. Lord Advocate (Court of Session, 1996)Canada: Ciarlariello v. Schacter (1993) and Rodriguez v. Attorney General of Canada (1993) (Supreme Court) Australia & New Zealand: Several progressive rulings, including Auckland Area Health Board v. Attorney General (1993) and Messiha v. South East Health (2004).Despite this strong judicial framework Indian courts have repeatedly urged the Union Government to enact comprehensive and definitive legislation relying solely on judicial guidelines leaves gaps in the system.A clear parliamentary law would officially codify these procedures and granting medical practitioners necessary legal certainty and sparing grieving families the devastating emotional and financial toll of fighting prolonged battles in court. The recent Harish Rana judgment exemplifies profound shift toward a more empathetic legal system. The Court boldly recognized that meaningful human life encompasses far more than mere "animal existence." By officially categorizing clinical nutrition and hydration as forms of life support that can be lawfully withdrawn and by emphasizing the right to quality end-of-life care. The Supreme Court ensured that the law serves as an instrument of human dignity for those in irreversible suffering rather than a tool for "biological entrapment." The underlying legal philosophy governing these decisions is perhaps best articulated by Lord Goff of Chieveley in the Airedale judgment. He clarified a crucial distinction regarding the withdrawal of care:

"I wish to add that, in cases of this kind, there is no question of the patient having committed suicide, nor therefore of the doctor having aided or abetted him in doing so. It is simply that the patient has, as he is entitled to do, declined to consent to treatment which might or would

have the effect of prolonging his life, and the doctor has, in accordance with his duty, complied with his patient's wishes."

3. Law Commission of India

The Indian Law Commission has played a pivotal role in shaping the national conversation around end-of-life rights, mental health and medical ethics through a series of critical evaluations. In its 196th report¹⁰ - the Commission advocated for the legalization of passive euthanasia, provided it is governed by a strict regulatory framework. It underscored the importance of honoring a patient's right to a dignified death suggesting that such profound decisions must involve collaborative consultations between medical professionals and the patient's family. Addressing the closely related issue of severe mental distress the Commission's 210th report harshly criticized Section 309 of the Indian Penal Code. It characterized the criminalization of attempted suicide as fundamentally inhumane. Arguing that such acts are symptoms of deep psychological anguish that require psychiatric care and compassion rather than penalization. The report emphasized that inflicting further punishment on an already suffering individual is unjust and its entirely counterproductive to suicide prevention or improved healthcare access. Building upon the judicial momentum generated by the Aruna Shanbaug case, the Commission 241st report¹¹ urgently called for formal and a comprehensive legislation on euthanasia. The Commission cautioned that while the courts had established passive euthanasia in principle, relying solely on judicial precedents was creating significant inconsistencies in how end-of-life care was administered. Furthermore, the report strongly endorsed the legal validation of advance medical directives, which would allow individuals to formally dictate their treatment preferences should they ever become terminally ill or incapacitated. However, despite these clear and repeated recommendations from the Law Commission, the Indian Parliament has not yet enacted dedicated legislation on the matter, leaving healthcare professionals to navigate these complex ethical scenarios guided exclusively by court judgments. The International Stance on Euthanasia

4. International Law

Currently, international humanitarian law does not recognize a fundamental "right to die." On the other hand significant human rights treaties explicitly emphasize the duty of states to

¹⁰ Titled "Medical Treatment to Terminally Ill Patients (Protection of Patients and Medical Practitioners)" Published in 2006

¹¹ Titled - "Passive Euthanasia - A Relook" Published in 2012

safeguard and uphold life. Of the 193 United Nations member states only a small number have legalized euthanasia, on the other hand the majority of global legislatures persist in opposing it. The emphasis on life is apparent in several crucial international documents:

The International Covenant on Civil and Political Rights (ICCPR, 1966): Article 6(1) states that every person has an inherent right to life, which cannot be arbitrarily taken away, and Article 7 protects individuals from inhuman or degrading treatment. The Convention on the Rights of the Child (CRC): Article 6(1) reflects this principle, ensuring the inherent right to life for all children. The Convention on the Rights of Persons with Disabilities (CRPD, 2006): This treaty requires member states to implement all necessary measures to guarantee that disabled individuals have the same right to life as everyone else.¹²

5. Jurisdictions Where Euthanasia is Legal

The Netherlands: In 2001, the Dutch Parliament enacted legislation that formally decriminalized euthanasia and physician-assisted suicide. This law mandates that this procedure be performed under medical oversight and precisely aligned with the patient's stated desires. Belgium, having implemented its euthanasia law in May 2002, permits physicians to aid terminally ill patients in expediting their deaths. The legislation stipulates stringent criteria: the patient must be of legal age, mentally sound, and enduring persistent, intolerable, and untreatable physical suffering. A written request is a prerequisite. If a patient is unable to compose the request, a designated proxy, with no vested interest in the patient's demise, may prepare the document. Advance directives are also acceptable for those who might later become incapacitated.

Luxembourg followed suit, decriminalizing euthanasia in March 2009, becoming the third nation to do so. Terminally ill patients can seek to end their lives, contingent upon approval from two independent physicians and a specialized medical panel.

Canada's Supreme Court ruling in *Carter v. Canada* led to the legalization of "medical assistance in dying" (MAID). This option is accessible to consenting adults (18 and older) suffering from a grievous and irremediable medical condition, where natural death is reasonably foreseeable.

¹² Convention on the Rights of Persons with Disabilities, 2006, art.10.

6. Primary Arguments Against Euthanasia

Those opposed to euthanasia present substantial ethical, legal, and medical objections, contending that its legalization could engender perilous ramifications for both at-risk individuals and the broader societal framework.

1. The potential for exploitation and hidden agendas is a significant concern. A primary worry involves the possibility of those with harmful intentions taking advantage of vulnerable individuals. A significant concern emerges within a societal context potentially lacking adequate ethical protections: the possibility that avaricious or overburdened relatives could coerce a vulnerable patient into consenting to euthanasia, motivated by the prospect of financial gain or the alleviation of caregiving responsibilities.

Critics contend that stringent legal and medical safeguards are indispensable to avert the potential misuse of euthanasia, thus safeguarding the patient's life and maintaining the ethical principles of medical practitioners, whose primary obligation is to avoid causing harm.

2. Constitutional Discrepancies and State Responsibility

Legally, Article 21 of the Indian Constitution enshrines the "Right to Life" as a natural, fundamental right. Critics posit that suicide or assisted death constitutes an unnatural cessation of life, rendering it fundamentally at odds with this constitutional guarantee. Furthermore, it is the primary duty of a welfare state to protect life and invest in public health. There is a strong apprehension that if euthanasia is legalized, governments might use it as an excuse to reduce funding for healthcare infrastructure. Opponents often point to international examples, suggesting that legalized euthanasia can lead to a systemic decline in the quality of care provided to the terminally ill.

3. The commercialization of healthcare presents a significant danger¹³. A troubling economic reality is already evident in numerous healthcare systems: economically disadvantaged patients frequently forgo essential, life-preserving treatments due to financial constraints. Should euthanasia be legalized, concerns arise that the commercial healthcare industry could, implicitly, promote it as a means of reducing costs. Consequently, euthanasia could potentially transform into a financially motivated "death sentence" for vulnerable populations, including the elderly, disabled individuals,

¹³ Gursahani R. Life and death after Aruna Shanbaug. *Indian J Med Ethics*. 2011; 8: 68–9. doi: 10.20529/IJME.2011.029.

and the impoverished, rather than representing a legitimate expression of personal autonomy.

4. Mental Health and the "Cry for Help"

Medical research consistently shows that the desire to prematurely end one's life is frequently linked to underlying psychiatric conditions, such as severe depression¹⁴, schizophrenia¹⁵, or substance abuse disorders¹⁶. In classical psychiatry, expressing a desire to die or attempting suicide is treated as a medical emergency and a desperate cry for help. Consequently, euthanasia requests necessitate rigorous psychiatric evaluation. Research, encompassing studies of individuals with advanced cancer, demonstrates a strong association between the wish to die and the presence of significant, untreated depression.¹⁷

5. The Fundamental Transition from "Cure" to "Care"

Progress in contemporary medicine has resulted in increased longevity, frequently accompanied by chronic, non-curable ailments. Because a "cure" is not always possible, medical and societal expectations must shift toward "care." The Role of Palliative Care: The goal of palliative care is to "add life to years, not just years to life" by managing pain and providing emotional support using low-cost, compassionate methods¹⁸. Lack of Awareness: Many requests for euthanasia are driven by a fear of intractable pain and a lack of awareness regarding alternatives. When patients are told that "nothing more can be done" to cure them, they despair. However, when introduced to high-quality palliative care that effectively controls their symptoms, many patients retract their requests for euthanasia. Opponents contend that a just society's obligation to uphold the "Right to Life" necessitates the provision of universally available, government-funded palliative care. Genuine dignity in the dying process, they argue, is not achieved through the artificial acceleration of death, but rather through the presence of a caring, human-centered healthcare team during a patient's final days.

¹⁴ Brådvik L, Mattisson C, Bogren M, Nettelblatt P. Long term suicide risk of depression in the Lundby cohort 1947-1997-severity and gender. *Acta Psychiatr Scand.* 2008;117:185-91. doi: 10.1111/j.1600-0447.2007.01136.x.

¹⁵ Campbell C, Fahy T. Suicide and schizophrenia. *Psychiatry.* 2005;4:65-7.

¹⁶ Griffin BA, Harris KM, McCaffrey DF, Morral AR. A prospective investigation of suicide ideation, attempts, and use of mental health service among adolescents in substance abuse treatment. *Psychol Addict Behav.* 2008;22:524-32. doi: 10.1037/a0012969.

¹⁷ Lonnqvist J. *The Oxford textbook of suicidology and suicide prevention.* Oxford: Oxford University Press; 2009. Major psychiatric disorders in suicide and suicide attempters; pp. 275-86.

¹⁸ Zyllicz Z, Finlay IG. Euthanasia and palliative care: reflections from The Netherlands and the UK. *J R Soc Med.* 1999;92:370-3. doi: 10.1177/014107689909200715.

7. Conclusion:

In conclusion, the legal tenets governing end-of-life care in India have undeniably evolved, progressing towards a more empathetic stance. This evolution acknowledges that a meaningful life transcends mere existence, and that the right to a dignified life encompasses the right to a dignified death.

However, the current system's complete reliance on court decisions to navigate the complex relationship between medicine, mercy, and law is not sustainable.

The Union Government must urgently introduce codified legislation to resolve the persistent legal uncertainties associated with voluntary, medically assisted dying. Establishing a detailed legal structure will legitimize advance medical directives, implement robust regulatory protections to prevent abuse, and unify procedural practices throughout the healthcare system. While guaranteeing accessible palliative care remains vital, definitive legislation is the only mechanism that can successfully balance the protection of vulnerable populations with a patient's fundamental right to bodily autonomy and a compassionate, dignified death. The Urgent Need for Legislative Reform.

The conclusion strongly emphasizes that relying solely on judicial frameworks is insufficient and highlights several critical reasons for immediate parliamentary action. While the courts have established passive euthanasia in principle, depending exclusively on judicial precedents creates significant inconsistencies in how end-of-life care is administered. A clear parliamentary law is needed to officially codify these procedures, which would grant medical practitioners the necessary legal certainty to perform their duties without fear of crossing into traditional definitions of abetment. Enacting comprehensive legislation would shield bereaved families from the profound emotional and financial strain associated with protracted legal disputes over securing compassionate end-of-life care for their relatives. Despite the Indian Law Commission's 241st report, which strongly advocated for formal, all-encompassing euthanasia legislation, Parliament has yet to pass specific laws to rectify this deficiency.