Page 2715 - 2729

INTERNATIONAL JOURNAL OF LAW MANAGEMENT & HUMANITIES

[ISSN 2581-5369]

Volume 9 | Issue 3

2026

© 2026 *International Journal of Law Management & Humanities*

Follow this and additional works at: https://www.ijlmh.com/

Under the aegis of VidhiAagaz – Inking Your Brain (https://www.vidhiaagaz.com/)

This article is brought to you for free and open access by the International Journal of Law Management & Humanities at VidhiAagaz. It has been accepted for inclusion in the International Journal of Law Management & Humanities after due review.

In case of **any suggestions or complaints**, kindly contact **support@vidhiaagaz.com**.

To submit your Manuscript for Publication in the **International Journal of Law Management & Humanities**, kindly email your Manuscript to **submission@ijlmh.com.**

Euthanasia and the Right to Die with Dignity: Constitutional Doctrine, Medical Practice and Comparative Lessons for India

TUSHAR GUPTA*

ABSTRACT

The Indian Supreme Court's engagement with euthanasia and end-of-life decision-making has progressively transformed Article 21 from a purely negative guarantee against arbitrary deprivation of life into a positive source of autonomy, bodily integrity and decisional privacy at the threshold of death. Beginning with Gian Kaur v. State of Punjab*, which rejected a freestanding "right to die" while acknowledging a possible "dignified procedure of death", the Court moved in* Aruna Ramachandra Shanbaug v. Union of India *to cautiously legitimise judicially supervised withdrawal of life-sustaining treatment in cases of persistent vegetative state.* Common Cause v. Union of India *completed this doctrinal trajectory by expressly recognising a right to die with dignity as part of Article 21, validating passive euthanasia and advance directives, and constructing an elaborate judge-made regulatory framework for living wills, subsequently streamlined in 2023 to ease procedural barriers. This paper argues that, despite its autonomy-enhancing rhetoric, Indian euthanasia jurisprudence remains structurally paternalistic and administratively fragile when applied in a health system marked by intensive-care constraints, palliative-care deficits and medico-legal anxieties. Drawing on comparative experience from the Netherlands, Belgium, Canada, the United Kingdom and selected U.S. jurisdictions, it contends that a workable Indian model must clearly distinguish ethically justified withdrawal of futile treatment from "euthanasia", embed end-of-life decisions within robust palliative and consent infrastructures, and shift primary norm-setting from the judiciary to Parliament and medical regulators. The paper ultimately advances a normative framework that treats the right to die with dignity as an institutional and distributive project rather than a purely doctrinal achievement. It proposes statutory clarification, procedural minimalism, and context-sensitive safeguards against coercion and inequality as the core design principles for an end-of-life regime that is both constitutionally faithful and practically feasible in India.*

Keywords: *Euthanasia, Right to die with dignity, Article 21, Bharatiya Nyaya Sanhita, Passive euthanasia, Advance directives, Living wills, Indian Supreme Court, End-of-life*

* Author is a student at Bharati Vidyapeeth Institute of Management and Research, New Delhi, India.

© 2026. International Journal of Law Management & Humanities [ISSN 2581-5369]

decision-making, Palliative care, Medical autonomy and dignity, Constitutional jurisprudence, Comparative constitutional law, Health law and bioethics.

I. INTRODUCTION

Contemporary Indian constitutional law has transformed Article 21 into a capacious source of rights that both constrain state power and structure intimate spheres of life, including the manner of dying.[1] Euthanasia and end-of-life decision-making sit at the intersection of this jurisprudential expansion and a chronically under-resourced health system in which intensive care, palliative support and legal literacy remain unevenly distributed.[2]

This paper takes the euthanasia debate in India as a lens through which to interrogate how constitutional doctrine, medical practice and institutional design interact in the governance of dying. The central claim is that the Court's emergent "right to die with dignity" line, culminating in *Common Cause* and its 2023 clarification, articulates a powerful autonomy- and dignity-based narrative but delegates to courts, hospital boards and individual physicians a regulatory task that requires legislative and systemic solutions.[3] Rather than asking whether India should "permit euthanasia" in the abstract, the argument proceeds from the more granular question of how Indian law can responsibly structure decisions to withhold or withdraw life-sustaining treatment and respect advance refusals of care in a socio-economic landscape marked by vulnerability, familial dominance and fragmented health governance.[4]

In methodological terms, the paper combines doctrinal analysis of the key decisions, *Gian Kaur*, *Aruna Shanbaug*, *Common Cause* and the 2023 modification, with comparative constitutional reasoning and engagement with the medical-ethics and critical-care literature on end-of-life care in India.[5] It also draws on global regulatory models from the Netherlands, Belgium, Canada, the United Kingdom and selected U.S. states to reflect on how different legal systems reconcile autonomy with protection of the vulnerable, and on what lessons such models hold for a constitutionally faithful, institutionally feasible Indian framework.[6]

[1] *Maneka Gandhi v. Union of India*, (1978) 1 SCC 248, 281-85 (India).
[2] WORLD HEALTH ORG., PALLIATIVE CARE (Fact Sheet, 2020), https://www.who.int/news-room/fact-sheets/detail/palliative-care (last visited Jan. 15, 2026).
[3] *Common Cause v. Union of India*, (2018) 5 SCC 1, 199-203 (India).
[4] AMARTYA SEN, INEQUALITY REEXAMINED 1-28 (1992).
[5] TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 99-148 (8th ed. 2019).
[6] *Carter v. Canada (Att'y Gen.)*, [2015] 1 S.C.R. 331 (Can.); *Airedale NHS Tr. v. Bland*, [1993] A.C. 789 (H.L.); Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001 (Neth.).

© 2026. International Journal of Law Management & Humanities [ISSN 2581-5369]

II. HISTORICAL EVOLUTION OF INDIAN JURISPRUDENCE ON EUTHANASIA

The modern trajectory begins with *Gian Kaur v. State of Punjab*, where a Constitution Bench rejected the proposition that Article 21 encompasses a right to die, thereby overturning *P. Rathinam*'s flirtation with decriminalising attempted suicide on constitutional grounds.[7] The Court conceptualised the right to life as inherently inconsistent with a claim to terminate one's existence, invoking the sanctity of life and the state's obligation to prevent suicide, yet it importantly opened a doctrinal window by acknowledging that the right to live with dignity may include a dignified process of death in cases of terminal illness.[8]

This unresolved tension between a prohibition on suicide and the possibility of dignified dying resurfaced in *Aruna Ramachandra Shanbaug v. Union of India*, where the Court confronted a petition seeking withdrawal of artificial nutrition from a nurse in a persistent vegetative state.[9] While the Court ultimately refused withdrawal on the particular facts, it drew a sharp distinction between "active" euthanasia, which positively causes death through lethal acts, and "passive" euthanasia, defined as the withholding or withdrawal of life-sustaining measures, and held that the latter could be permissible in rare cases subject to stringent High-Court-supervised procedures.[10] The decision located permissibility not in any general right to die, but in an interpretation of Article 21 that treated continued invasive treatment with no prospect of recovery as potentially inconsistent with dignity, thus reading *Gian Kaur*'s obiter on dignified death as a narrow constitutional foothold.[11]

For nearly seven years after *Aruna Shanbaug*, the judicially crafted mechanism remained largely theoretical, with little evidence of routine resort to the prescribed writ-jurisdiction route in clinical practice.[12] During this period, professional bodies such as the Indian Society of Critical Care Medicine and the Indian Association of Palliative Care issued practice guidelines that explicitly rejected euthanasia and physician-assisted suicide but endorsed ethically justified withdrawal of futile treatment, underscoring the gap between the Court's "passive euthanasia" vocabulary and medical discourse on end-of-life care.[13]

---

[7] *Gian Kaur v. State of Punjab*, (1996) 2 SCC 648, 659-60 (India) (overruling *P. Rathinam v. Union of India*, (1994) 3 SCC 394 (India)).
[8] *Id.* at 661-62.
[9] *Aruna Ramachandra Shanbaug v. Union of India*, (2011) 4 SCC 454, 470-75 (India).
[10] *Id.* at 487-90.
[11] *Id.* at 495-96.
[12] R.K. Mani et al., *Guidelines for End-of-Life and Palliative Care in Indian Intensive Care Units: ISCCM Consensus Ethical Position Statement*, 16 INDIAN J. CRITICAL CARE MED. 121, 121-26 (2012).
[13] INDIAN SOC'Y OF CRITICAL CARE MED., ISCCM GUIDELINES ON LIMITATION OF LIFE-SUSTAINING TREATMENT AND PALLIATIVE CARE IN INTENSIVE CARE UNITS (2014); INDIAN ASS'N OF PALLIATIVE CARE, POSITION STATEMENT ON EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE (2012).

© 2026. International Journal of Law Management & Humanities [ISSN 2581-5369]

Common Cause v. Union of India marked the doctrinal pivot. A Constitution Bench not only affirmed the legitimacy of withdrawing life support in irreversibly terminal or vegetative conditions, but also recognised advance directives, or living wills, as constitutionally protected instruments through which competent persons could prospectively refuse invasive treatment in defined contingencies.[14] The Court now explicitly articulated a "right to die with dignity" as an aspect of Article 21, positioning it alongside prior autonomy- and privacy-centric decisions such as *K.S. Puttaswamy*.[15] In doing so, it both extended and quietly re-read *Gian Kaur*: the earlier rejection of a generic right to die was retained, but the possibility of dignified dying through the withdrawal of non-beneficial treatment and respect for prior refusals was elevated into a fundamental right grounded in dignity and bodily integrity.[16]

The *Common Cause* guidelines, however, created a labyrinthine procedure involving two medical boards, judicial-magistrate attestation and district-court custody of directives, an architecture that, as the Court itself later acknowledged in 2023, proved too cumbersome to operationalise.[17] The 2023 modification responded to evidence that hardly any valid advance directives had been implemented under the original framework and substantially relaxed procedural requirements by allowing attestation by a notary or gazetted officer and integrating directives into a national digital health record, while also simplifying the composition and timelines of medical boards.[18] This evolution reveals a jurisprudence struggling to reconcile its own autonomy-driven rhetoric with concerns about abuse and institutional incapacity, resulting in repeated judicial recalibration of procedures in the absence of legislative intervention.[19]

III. AUTONOMY, DIGNITY AND ARTICLE 21: DOCTRINAL REINTERPRETATION

The doctrinal re-reading of Article 21 in the euthanasia context cannot be understood in isolation from the broader trajectory of the right to life, which has steadily incorporated notions of autonomy, privacy and bodily integrity.[20] *Gian Kaur*'s refusal to constitutionalise suicide coexisted with a recognition that the right to life is not limited to mere animal existence but includes a dignified life and, at its natural end, a dignified process of dying.[21] This formulation remained underdeveloped in 1996, but it set the stage for later decisions to treat the insistence

[14] *Common Cause*, (2018) 5 SCC at 186-214.
[15] *K.S. Puttaswamy v. Union of India*, (2017) 10 SCC 1, 298-306 (India).
[16] *Common Cause*, (2018) 5 SCC at 210-14.
[17] *Id.* at 214-33.
[18] *Common Cause v. Union of India* (Modification Order Jan. 24, 2023), (2023) SCC OnLine SC 99 (India).
[19] MARK TUSHNET, WEAK COURTS, STRONG RIGHTS 39-57 (2008).
[20] *Francis Coralie Mullin v. Adm'r, Union Territory of Delhi*, (1981) 1 SCC 608, 618 (India).
[21] *Gian Kaur*, (1996) 2 SCC at 661.

© 2026. International Journal of Law Management & Humanities [ISSN 2581-5369]

on invasive, futile treatment as inconsistent with the "dignity" component of Article 21 rather than as an expression of its protection of life.[22]

By the time of *Common Cause*, the Court's Article 21 jurisprudence had been transformed by privacy and decisional-autonomy cases, most notably *Puttaswamy*, which characterised privacy as a facet of life and personal liberty encompassing decisional autonomy over intimate matters such as reproduction and bodily choices.[23] *Common Cause* explicitly drew on this line to argue that end-of-life decisions, including the refusal of life-sustaining treatment through advance directives, lie at the core of personal autonomy and bodily integrity, such that forcing invasive treatment on a competent adult, or continuing it when the person has clearly refused it in advance, amounts to an unconstitutional invasion of Article 21 rights.[24]

The doctrinal move is subtle but significant. Rather than treating the right to die with dignity as a "negative" right to demand death, the Court framed it as a right to be free from non-consensual medical intrusion and from the indignity of artificially prolonged biological existence devoid of consciousness or meaningful relational life.[25] This approach aligns with bioethical conceptions of autonomy, which emphasise informed, voluntary choice and respect for bodily integrity, and shifts the focus from state "assistance in dying" to non-interference with reasoned refusals of treatment.[26]

At the same time, the jurisprudence reveals an unresolved tension between autonomy and vulnerability. The Court repeatedly expressed anxiety about the potential coercion of elderly or terminally ill persons by relatives seeking to avoid caregiving burdens, and about socio-economic pressures that might push the poor to forgo life-sustaining treatment in order to spare families catastrophic expenditure.[27] These concerns led the Court to superimpose layers of medical and judicial oversight on what is, at its core, a decisional-privacy claim, thereby partially displacing the locus of decision-making from the patient to institutions ostensibly tasked with verifying voluntariness and best interests.[28]

Consequently, while the rhetoric of autonomy and dignity is robust, the doctrinal implementation remains guarded. The right to die with dignity is recognised, but its exercise is heavily mediated by state-sanctioned actors, and the jurisprudence stops short of engaging with

[22] *Aruna Shanbaug*, (2011) 4 SCC at 490-92.
[23] *Puttaswamy*, (2017) 10 SCC at 298-306.
[24] *Common Cause*, (2018) 5 SCC at 199-203.
[25] *Id.* at 203-05.
[26] BEAUCHAMP & CHILDRESS, *supra* note 5, at 101-06.
[27] *Common Cause*, (2018) 5 SCC at 208-10.
[28] *Id.* at 214-18.

© 2026. International Journal of Law Management & Humanities [ISSN 2581-5369]

active euthanasia or physician-assisted dying, which remain criminal offences under the Bharatiya Nyaya Sanhita, 2023.[29] The right is thus narrower than in jurisdictions that treat medically assisted dying itself as a permissible option under stringent safeguards, yet broader than a mere right to palliative care, in so far as it constitutionally entrenches the permissibility of withdrawing futile treatment and respecting advance refusals.[30]

IV. REGULATORY ARCHITECTURE AND INSTITUTIONAL FEASIBILITY IN INDIA

The regulatory framework for passive euthanasia and living wills in India is, at present, almost entirely judge-made, supplemented only indirectly by professional guidelines and administrative circulars.[31] *Aruna Shanbaug* initiated this trend by crafting an ad hoc procedure requiring High Courts to entertain petitions to withdraw life support and to constitute a medical board to advise on the patient's condition and best interests.[32] This model treated judicial supervision as the primary safeguard against abuse, but it was normatively and practically ill-suited to routine intensive-care decision-making, which often unfolds rapidly in tertiary hospitals and district facilities with limited legal support.[33]

Common Cause extended the regulatory canvas by laying down detailed procedures both for institutional decision-making in present-consent cases and for the execution and implementation of advance directives.[34] For living wills, the Court required that the document be executed by a competent adult in the presence of two witnesses, attested by a judicial magistrate and deposited with the district court, with multiple medical boards and judicial oversight mandated at the implementation phase.[35] For patients without directives, an institutional protocol involving primary and secondary medical boards and, in some formulations, judicial approval was prescribed, again reflecting a strong emphasis on ex ante safeguards.[36]

Evidence from clinicians and legal commentators suggests that this intricate architecture rendered the right almost illusory in practice.[37] Hospitals lacked clear administrative pathways to identify valid directives, district courts were not institutionally equipped to serve as repositories and gatekeepers for medical documents, and the timelines envisaged in the

[29] The Bharatiya Nyaya Sanhita, 2023, No. 45, Acts of Parliament, 2023, §§ 100-105, 108, 226 (India).
[30] *Carter*, [2015] 1 S.C.R. at 377-79.
[31] LAW COMM'N OF INDIA, 241ST REPORT ON PASSIVE EUTHANASIA: A RELOOK (2012).
[32] *Aruna Shanbaug*, (2011) 4 SCC at 499-502.
[33] Mani et al., *supra* note 12, at 123-25.
[34] *Common Cause*, (2018) 5 SCC at 214-33.
[35] *Id.* at 220-25.
[36] *Id.* at 225-29.
[37] M.R. Rajagopal & Gayatri Palat, *Kerala, India: Status of Cancer Pain Relief and Palliative Care*, 24 J. PAIN & SYMPTOM MGMT. 191, 3-5 (2002).

judgment were unrealistic in critical-care contexts where decisions about ventilator withdrawal or non-escalation of support are often time-sensitive.[38] The near-absence of reported instances of fully compliant directives being implemented under the 2018 regime prompted the Court to revisit its own guidelines.[39]

The 2023 modification sought to address these feasibility problems by de-judicialising key steps and integrating the regime into existing administrative and health-information infrastructure.[40] The requirement of a judicial magistrate's attestation for advance directives was replaced with attestation by a notary or gazetted officer; directives were to be uploaded to the national digital health record for easier access; and the composition and functioning of medical boards were simplified and made subject to clearer timelines.[41] These changes represent a partial shift from court-centric safeguards to a more bureaucratic medical model, although they still emanate from judicial authority rather than statute.[42]

From a separation-of-powers perspective, the Court's assumption of quasi-legislative functions raises concerns.[43] In the absence of a dedicated euthanasia statute or amendments to the Bharatiya Nyaya Sanhita, 2023 and to health legislation, the normative framework rests on constitutional decisions that bind lower courts but may not be well internalised by health administrators, insurers or professional regulators.[44] Judicial guidelines lack the deliberative advantages, stakeholder consultation and iterative amendment processes associated with legislation, and they place the burden of norm specification on a forum ill-equipped to account for the diversity of Indian health-care settings, including small private nursing homes and public facilities with minimal intensive-care capacity.[45]

Institutional feasibility also hinges on bureaucratic and professional capacity. The implementation of the revised guidelines presupposes reliable digital infrastructure for health records, workable mechanisms for convening independent medical boards in rural and peri-urban areas, and clinicians comfortable with navigating medico-legal risks in the shadow of ambiguous criminal-law provisions.[46] Without concomitant statutory reform, clear indemnity provisions for good-faith compliance, and integration with existing frameworks such as state

[38] Mani et al., *supra* note 12, at 124-26.
[39] *Common Cause v. Union of India* (Modification Order Jan. 24, 2023), *supra* note 18.
[40] *Id.*
[41] NAT'L HEALTH AUTH., GOV'T OF INDIA, AYUSHMAN BHARAT DIGITAL MISSION: OPERATIONAL GUIDELINES (2022), https://abdm.gov.in (last visited Jan. 15, 2026).
[42] TUSHNET, *supra* note 19, at 41-45.
[43] LON L. FULLER, THE MORALITY OF LAW 33-94 (rev. ed. 1969).
[44] LAW COMM'N OF INDIA, 196TH REPORT, MEDICAL TREATMENT TO TERMINALLY ILL PATIENTS (2006).
[45] *Id.*
[46] NAT'L HEALTH AUTH., *supra* note 41.

© 2026. International Journal of Law Management & Humanities [ISSN 2581-5369]

clinical-establishments legislation, the judicial architecture risks reproducing the earlier gap between constitutional ideals and clinical practice, albeit with somewhat reduced procedural friction.[47]

V. MEDICAL PRACTICE REALITIES AND ETHICAL TENSIONS

The Court's euthanasia jurisprudence supervenes on an end-of-life-care landscape marked by fragmented ICU practices, inadequate palliative care and deep-seated cultural norms around familial decision-making.[48] Studies of Indian intensive-care units indicate that decisions to withhold or withdraw life-sustaining treatment are already made, often informally, on grounds of futility, financial constraints or perceived poor prognosis, without systematic documentation or structured ethics consultation.[49] This shadow practice of "silent" limitation of treatment coexists uneasily with formal legal prohibitions on euthanasia and a limited awareness of the constitutional protections for the withdrawal of futile treatment.[50]

Palliative-care availability remains patchy, with only a minority of institutions offering comprehensive pain management, psychosocial support and advance-care planning; where such services exist, they tend to be concentrated in urban tertiary centres or in certain states with stronger hospice traditions.[51] The absence of routine palliative integration means that end-of-life decisions are often framed as binary choices between maximal invasive care and abandonment, rather than as part of a continuum of care that transitions from curative intent to comfort-focused management.[52] In such settings, formalising rights to refuse life-sustaining treatment risks being misunderstood as a licence to withdraw care altogether unless it is accompanied by a parallel strengthening of palliative services.[53]

Consent dynamics in Indian hospitals complicate the autonomy narrative. Family members frequently act as de facto decision-makers, with clinicians seeking "family consent" for withdrawal or non-escalation of treatment, sometimes documented on hospital forms that emphasise financial impossibility rather than patient preference.[54] Patients are often excluded from conversations about prognosis and options, particularly where cultural norms valorise protective non-disclosure; this creates a structural asymmetry that undermines the ideal of

[47] INDIAN COUNCIL OF MED. RSCH., NATIONAL ETHICAL GUIDELINES FOR BIOMEDICAL AND HEALTH RESEARCH INVOLVING HUMAN PARTICIPANTS ch. 7 (2017).
[48] Mani et al., *supra* note 12, at 121-26.
[49] *Id.*
[50] INDIAN ASS'N OF PALLIATIVE CARE, *supra* note 13.
[51] WORLD HEALTH ORG., *supra* note 2.
[52] Rajagopal & Palat, *supra* note 37.
[53] *Id.*
[54] Mani et al., *supra* note 12.

© 2026. International Journal of Law Management & Humanities [ISSN 2581-5369]

informed, voluntary end-of-life choice central to *Common Cause*.[55] In practice, advance directives may be executed by a relatively small, literate and privileged segment, while the majority continue to experience paternalistic or family-driven decisions without meaningful participation.[56]

Resource constraints and physician-liability anxieties further shape practice. Intensive-care beds are scarce and expensive, especially in private facilities where out-of-pocket expenditures can be catastrophic for families, creating pressure to discontinue treatment when financial limits are reached, even absent clear futility.[57] At the same time, physicians face the threat of criminal prosecution under the Bharatiya Nyaya Sanhita, 2023 provisions on culpable homicide, murder and abetment of suicide, as well as civil negligence claims, if withdrawal decisions are later challenged as premature or coerced.[58] In the absence of clear statutory immunities for good-faith compliance with constitutional guidelines and professional standards, the rational response of many clinicians is defensive medicine: to prolong treatment in order to avoid allegations of "letting the patient die", even when such treatment conflicts with emerging norms of dignified dying.[59]

These realities generate ethical tensions not fully captured by doctrinal debates. The central question in many Indian ICUs is less whether euthanasia should be permitted, and more how to navigate ethically the inevitable limitations of treatment in a context of financial scarcity, family dominance and legal uncertainty.[60] A legal framework attentive to these factors must focus on normalising transparent, documented end-of-life discussions, embedding palliative care as a default, and providing legal cover for the ethically appropriate withdrawal of non-beneficial treatment, rather than framing every limitation of treatment through the lens of "euthanasia".[61]

VI. COMPARATIVE CONSTITUTIONAL PERSPECTIVES

Comparative experience illustrates the diversity of legal techniques for regulating euthanasia and assisted dying, and it underscores that India's path, constitutionalising passive euthanasia without legislative codification, is unusual.[62] The Netherlands' Termination of Life on Request

[55] *Common Cause*, (2018) 5 SCC at 199-203.
[56] SEN, *supra* note 4, at 15-21.
[57] WORLD BANK, OUT-OF-POCKET EXPENDITURE (% OF CURRENT HEALTH EXPENDITURE): INDIA (2023), https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS?locations=IN (last visited Jan. 15, 2026).
[58] The Bharatiya Nyaya Sanhita, 2023, No. 45, Acts of Parliament, 2023, §§ 100-105, 108, 226 (India) (criminal liability for culpable homicide, murder, abetment of suicide, and attempt to commit suicide to compel or restrain a public servant).
[59] Mani et al., *supra* note 12.
[60] BEAUCHAMP & CHILDRESS, *supra* note 5.
[61] INDIAN SOC'Y OF CRITICAL CARE MED., *supra* note 13.
[62] Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001 (Neth.).

and Assisted Suicide (Review Procedures) Act 2001 legalises both euthanasia and physician-assisted suicide, subject to stringent due-care criteria, including a voluntary and well-considered request, unbearable suffering with no prospect of improvement, informed consent and consultation with at least one independent physician, with ex post review by regional committees.[63] Belgium's 2002 Euthanasia Act adopts a similar structure, subsequently extended to competent minors in restricted circumstances, and requires written requests and multiple safeguards, with criminal liability for non-compliant acts.[64]

Canada initially legalised medical assistance in dying (MAiD) through judicial invalidation of the blanket prohibition on assisted suicide in *Carter v. Canada*, followed by federal legislation establishing a regime for eligible adults with grievous and irremediable medical conditions to request physician-administered or self-administered lethal medication.[65] The Canadian model combines constitutional impetus with detailed statutory criteria, reporting obligations and oversight, and it has undergone further reform to broaden eligibility and respond to concerns about access and protection of the vulnerable.[66] In both the Dutch-Belgian and the Canadian contexts, the legality of positive acts that directly cause death is accepted, but it is heavily conditioned by statutory safeguards and professional regulation, reflecting a high degree of trust in institutional capacity to manage such regimes.[67]

By contrast, the United Kingdom and most U.S. states prohibit active euthanasia and physician-assisted suicide under criminal law, but permit the withdrawal of life-sustaining treatment and respect for advance decisions as manifestations of patient autonomy.[68] In the United Kingdom, the common law and the Mental Capacity Act 2005 recognise advance decisions to refuse treatment as legally binding if valid and applicable, and landmark decisions such as *Airedale NHS Trust v. Bland* have affirmed that withdrawing artificial nutrition from patients in a permanent vegetative state can be lawful, provided that best-interest standards and procedural safeguards are met.[69] Several U.S. states, for example Oregon, Washington, Vermont and California, have enacted "Death with Dignity" statutes that allow physician-assisted suicide for terminally ill, competent adults, but euthanasia remains illegal, and all states recognise some

[63] *Id.*
[64] Act on Euthanasia of May 28, 2002 (Belg.).
[65] *Carter v. Canada (Att'y Gen.)*, [2015] 1 S.C.R. 331 (Can.).
[66] Criminal Code, R.S.C. 1985, c. C-46, §§ 241.1-241.4 (Can.).
[67] GOV'T OF CAN., FOURTH ANNUAL REPORT ON MEDICAL ASSISTANCE IN DYING IN CANADA 2023 (2024), https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html (last visited Jan. 15, 2026).
[68] Mental Capacity Act 2005, c. 9 (U.K.).
[69] *Airedale NHS Trust v. Bland*, [1993] A.C. 789 (H.L.).

© 2026. International Journal of Law Management & Humanities [ISSN 2581-5369]

form of advance directive and health-care proxy governing the refusal of life-sustaining treatment.[70]

India's current position is closest, in formal terms, to the United Kingdom and majority U.S. model: active euthanasia and physician-assisted suicide remain criminal, while the withdrawal of life-sustaining treatment and advance refusal are permitted under tightly constrained conditions.[71] The key differences lie in the source and design of regulation. In the United Kingdom and many U.S. states, advance directives and end-of-life decisions are governed by statutes and professional guidance, whereas in India they are primarily governed by constitutional judgments supplemented by non-binding clinical guidelines.[72] Moreover, the Indian jurisprudence uses the vocabulary of "passive euthanasia", a term explicitly rejected by bodies such as the Indian Council of Medical Research, which distinguish ethically justified limitation of treatment from euthanasia as an intention to cause death.[73]

Comparative analysis also highlights the importance of social context. Jurisdictions that have legalised euthanasia or MAiD typically possess relatively robust health-care systems, established palliative services and regulatory-oversight mechanisms, even as debates continue over "slippery slopes" and the adequacy of safeguards.[74] In India, by contrast, basic access to pain relief, intensive care and legal literacy is uneven, and socio-economic inequality shapes medical decisions in ways that magnify the risks of subtle coercion.[75] These differences caution against the wholesale transplantation of expansive euthanasia regimes and instead point toward a more incremental approach focused on clarifying the law on treatment limitation and advance refusals, while strengthening the underlying health-care and regulatory infrastructure.[76]

VII. RISKS, SAFEGUARDS AND STRUCTURAL LIMITATIONS

Any rights-based framework for end-of-life decisions in India must confront the risk that ostensibly voluntary choices may be shaped by coercion, dependence and inequality.[77] Elderly persons, women, persons with disabilities and the chronically ill may experience direct or indirect pressure from caregivers "not to be a burden", particularly where families face severe

[70] Or. Rev. Stat. §§ 127.800-.995; Wash. Rev. Code §§ 70.245.010-.903; Cal. Health & Safety Code §§ 443-443.22.
[71] *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 278-81 (1990).
[72] GEN. MED. COUNCIL, TREATMENT AND CARE TOWARDS THE END OF LIFE: GOOD PRACTICE IN DECISION MAKING (2010).
[73] INDIAN COUNCIL OF MED. RSCH., *supra* note 47.
[74] OECD, HEALTH AT A GLANCE: ASIA/PACIFIC 2022 (2022), https://www.oecd.org/health/health-at-a-glance-asia-pacific-2022-2bb54f36-en.htm (last visited Jan. 15, 2026).
[75] SEN, *supra* note 4.
[76] WORLD HEALTH ORG., *supra* note 2.
[77] UNESCO, UNIVERSAL DECLARATION ON BIOETHICS AND HUMAN RIGHTS arts. 5-7 (2005).

© 2026. International Journal of Law Management & Humanities [ISSN 2581-5369]

financial strain or caregiving fatigue.[78] In a setting where filial and familial expectations carry significant weight, the prospect of subtle persuasion to execute advance directives or consent to the withdrawal of treatment is real, and difficult to detect through formal safeguards alone.[79]

Socio-economic inequality amplifies these vulnerabilities. For poorer patients, choices about continuing intensive care often involve weighing the chance of recovery against indebtedness or loss of livelihood for dependants; in such cases, a "decision" to discontinue treatment may reflect constrained options rather than genuine preference.[80] A legal regime that formalises the refusal of life-sustaining treatment without addressing underlying financial barriers risks legitimising what are, in effect, economically compelled deaths.[81] Conversely, affluent patients may access prolonged intensive care and legal advice to optimise their end-of-life planning, deepening distributive disparities in the realisation of the dignified-dying ideal.[82]

Regulatory capture and institutional self-interest present additional risks. Hospitals might be tempted to invoke futility or anticipated directives to free up ICU beds or avoid litigation, especially in resource-constrained public facilities, while private institutions may lean towards continued treatment to maximise revenue, unless constrained by external oversight.[83] Without transparent documentation and audit mechanisms, the line between ethically justified treatment limitation and decisions influenced by institutional convenience or financial incentives can become blurred.[84] The composition and accountability of medical boards or ethics committees therefore become critical to ensuring that safeguards are not merely cosmetic.[85]

The judge-made nature of the current framework is itself a structural limitation. Constitutional guidelines, even when revised, are not embedded in a comprehensive system of training, monitoring and sanction; compliance depends on voluntary uptake by hospitals and variable interpretation by state authorities.[86] The absence of clear statutory immunities for physicians acting in good faith under accepted protocols sustains liability anxieties and may lead to both over-treatment and covert, undocumented withdrawal of care.[87] The lack of integration with mental-health and social-care services also means that requests to refuse treatment may be

[78] SEN, *supra* note 4.
[79] *Id.*
[80] WORLD BANK, *supra* note 57.
[81] *Id.*
[82] OECD, *supra* note 74.
[83] TUSHNET, *supra* note 19.
[84] FULLER, *supra* note 43.
[85] LAW COMM'N OF INDIA, *supra* note 31.
[86] *Id.*
[87] The Bharatiya Nyaya Sanhita, 2023, No. 45, Acts of Parliament, 2023, §§ 100-105, 108, 226 (India) (setting the criminal-law backdrop for physician liability in withdrawal-of-treatment decisions).

© 2026. International Journal of Law Management & Humanities [ISSN 2581-5369]

accepted or acted upon without adequate exploration of treatable depression, family conflict or social-support options.[88]

Safeguards must therefore be multi-layered and context-sensitive. Procedural checks, such as witnesses, attestations and medical boards, are necessary but insufficient; they must be complemented by substantive criteria emphasising voluntariness, informed understanding and independent assessment for vulnerable groups, as well as by systemic measures such as universal access to palliative care and financial-risk protection for serious illness.[89] Properly designed, such safeguards can reduce the risk that dignified-dying rights become, in practice, mechanisms that disproportionately expose the marginalised to premature death while preserving maximal choice for the privileged.[90]

VIII. Reform proposals and normative framework

A normatively grounded reform agenda for India should begin by reframing the legal discourse around end-of-life care. The term "passive euthanasia" should be abandoned in favour of a clearer distinction between, first, the lawful withholding or withdrawal of futile or burdensome treatment in accordance with patient preferences and best interests, and, second, prohibited acts intended to cause death, such as the administration of lethal medication.[91] Legislative and regulatory instruments should explicitly endorse the former as part of good medical practice and constitutional rights, while retaining criminal prohibitions on active euthanasia unless and until there is a democratically deliberated choice to revisit them.[92]

First, Parliament should enact a comprehensive End-of-Life Care and Advance Directives Act codifying the principles articulated in *Common Cause* and the 2023 modification, but simplifying procedures and aligning them with existing health-law frameworks.[93] Such a statute should define legally binding advance directives to refuse specified treatments under defined conditions, with straightforward execution formalities, for example two witnesses and registration in an electronic health registry, and clear revocation mechanisms.[94] It should establish default decision-making hierarchies and best-interest standards for incapacitated patients without directives, incorporating consultation with family but centring the patient's

[88] World Health Org., *supra* note 2.
[89] Beauchamp & Childress, *supra* note 5.
[90] Sen, *supra* note 4.
[91] Indian Council of Med. Rsch., *supra* note 47.
[92] The Bharatiya Nyaya Sanhita, 2023, No. 45, Acts of Parliament, 2023 (India) (active euthanasia continues to fall within the general homicide and abetment offences and remains criminal absent statutory reform).
[93] *Common Cause*, (2018) 5 SCC 1; *Common Cause v. Union of India* (Modification Order Jan. 24, 2023), *supra* note 18.
[94] Mental Capacity Act 2005, c. 9 (U.K.).

© 2026. International Journal of Law Management & Humanities [ISSN 2581-5369]

previously expressed values where these are known.[95] It should also provide explicit immunity for clinicians who, in good faith and in accordance with prescribed protocols and professional guidelines, withhold or withdraw life-sustaining treatment in conformity with directives or best-interest determinations.[96]

Secondly, regulatory design should favour institutional integration over ad hoc judicialisation. Hospital-level ethics or end-of-life-care committees, including clinicians, nursing staff, palliative specialists and lay members, can offer case-based deliberation and documentation, subject to periodic external audit, rather than requiring recourse to courts except in cases of serious dispute.[97] National and state health authorities, in collaboration with professional bodies and the ICMR, should issue binding clinical protocols that operationalise statutory principles across diverse settings, including resource-limited facilities, and should mandate training in end-of-life communication and documentation.[98]

Thirdly, the right to die with dignity must be embedded within a broader rights-based approach to health. Universal access to essential palliative care, including opioids for pain management and psychosocial support, should be recognised as a component of the right to health and supported through dedicated funding, training and integration into primary and tertiary care.[99] Financial-risk-protection mechanisms, through insurance, government schemes or subsidies, should reduce the extent to which choices about continuing treatment are driven by catastrophic-cost considerations rather than by preferences or clinical judgment.[100] Such structural reforms are crucial to ensuring that autonomy at the end of life is not a privilege of the well-off.[101]

Finally, a deliberative, pluralist process is normatively preferable to ongoing judicial innovation. Law Commission reports, parliamentary-committee hearings and broad-based consultations with clinicians, patients' groups, disability advocates, religious organisations and ethicists can help shape a nuanced statutory framework that reflects India's social diversity.[102] The constitutional right to die with dignity should be understood not as a judicially exhausted concept but as a guiding principle directing legislative and policy choices: a commitment to ensure that no person is forced to endure burdensome, non-beneficial treatment contrary to their

[95] *Airedale NHS Trust v. Bland*, *supra* note 69.
[96] LAW COMM'N OF INDIA, *supra* note 44.
[97] GEN. MED. COUNCIL, *supra* note 72.
[98] INDIAN COUNCIL OF MED. RSCH., *supra* note 47.
[99] WORLD HEALTH ORG., *supra* note 2.
[100] WORLD BANK, *supra* note 57.
[101] SEN, *supra* note 4.
[102] LAW COMM'N OF INDIA, *supra* note 31.

© 2026. International Journal of Law Management & Humanities [ISSN 2581-5369]

values, and that every person can expect pain relief, respect and relational support as death approaches.[103]

IX. CONCLUSION

The Indian Supreme Court's euthanasia jurisprudence charts a complex path between the sanctity of life and the autonomy of the dying, ultimately recognising a right to die with dignity that encompasses the withdrawal of futile treatment and the legal force of advance directives.[104] Yet this jurisprudential achievement remains precarious so long as it rests on intricate judicial guidelines rather than on a coherent statutory and institutional ecosystem attuned to the realities of Indian health care.[105]

Comparative experience suggests that the legitimacy and safety of end-of-life regimes depend less on whether active euthanasia is permitted than on the clarity of legal rules, the robustness of palliative and consent infrastructures, and the seriousness with which systems confront inequality and vulnerability.[106] For India, the priority is therefore not to emulate the Dutch or Canadian models wholesale, but to consolidate a context-appropriate framework that normalises ethically justified limitation of treatment, strengthens palliative care, mitigates financial coercion, and provides clinicians with clear, protective guidance.[107]

Conceived in this way, the right to die with dignity under Article 21 is best understood as an institutional and distributive project rather than a solitary claim against the state.[108] Its realisation requires Parliament, regulators, professional bodies and health-care institutions to share responsibility for constructing conditions in which autonomy, dignity and protection at the end of life are not theoretical entitlements but lived realities across India's diverse clinical and social settings.[109]

*****

[103] UNESCO, *supra* note 77.
[104] *Common Cause*, (2018) 5 SCC at 186-214.
[105] TUSHNET, *supra* note 19.
[106] OECD, *supra* note 74.
[107] WORLD HEALTH ORG., *supra* note 2.
[108] SEN, *supra* note 4.
[109] FULLER, *supra* note 43.

© 2026. International Journal of Law Management & Humanities [ISSN 2581-5369]