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**“ EUTHANASIA AND RIGHT TO DIE :
NAVIGATING THE BOUNDARIES OF LAW AND CRIME ”**

AUTHOR:- CHHAVI KAUSHIK

Abstract

This paper explores India's changing legal and constitutional stance on euthanasia and the right to die. The dispute revolves around whether the right to life and personal liberty guaranteed by Article 21 of the Constitution encompasses the right to a dignified death. The study follows the evolution of the legal system from early rulings that rejected this right to later acceptance of living wills and passive euthanasia. A move toward patient autonomy has been reflected in landmark decisions that have progressively broadened the definition of dignity in death. Recent judicial interventions have further simplified procedural safeguards and enabled practical implementation in exceptional cases. The study also examines ethical issues, such as the necessity to safeguard vulnerable people and the possibility of abuse. It finds that although while India has achieved great strides through court rulings, comprehensive legislation is still desperately needed to strike a balance between social interests, medical ethics, and individual autonomy.

Additionally, the paper considers the role of medical practitioners, family consent, and institutional oversight in end-of-life decisions. It ultimately argues for clearer statutory guidance to reduce ambiguity and ensure consistency in judicial and medical practice.

Keywords - Right to Die , Euthanasia ,Article 21 ,Passive Euthanasia , Living Will.

1. Introduction

The actual meaning of euthanasia originates from two Greek words, "eu" means good, and "thanatos" is death. It is a "good death." So far this definition seems uncomplicated and even compassionate, but the reality that exists behind euthanasia may be less uncomplicated than one thinks. Euthanasia is defined by legal and medical standards as the intentional ending of an individual's life for the purpose of alleviating prolonged suffering. This most often occurs with individuals with terminal illnesses or who will not have a chance of recovery. The definition of euthanasia breaks down into the two categories of active or passive. Active euthanasia is the immediate outcome of an individual taking a specific action (i.e. giving a person a lethal injection), whereas passive euthanasia involves removing the means to keep an individual alive by either withdrawing or withholding life-sustaining treatment and allowing

the disease process to occur. Courts in India have, somewhat cautiously, accepted this second form under certain conditions, though even that acceptance comes wrapped in procedures and safeguards.

But The underlying nature of these categories prompts an important and complex question: Is there such a thing as an individual's "right to die"? Within the context of the Constitution of India is Article 21, which guarantees the citizen's rights to life and personal liberty. This right has been interpreted over time to include dignity as part of the right, rather than just a means of ensuring the citizen lives. However, while it can be understood to include dignity at the end of one's life, the legal system seems hesitant to include the right to die. As indicated earlier, this is a tug-of-war between the traditional value placed on the sanctity of life that society historically has held and the individual, who may, for an extended period, lie on a hospital bed reliant on machines with no reasonable possibility of recoverability. In such cases, autonomy starts to matter in a very real, almost urgent way. The debate, then, is not just legal. It is deeply human, and perhaps that is why it remains unresolved in any simple sense.

The Indian Judiciary has influenced the legal framework pertaining to Euthanasia throughout its history. The Courts originally took a restrictive view and ruled that the Right to Life did not include the Right to Die. Eventually though, the Courts began to see that requiring individuals who are in a Persistent Vegetative State or who are experiencing irreversible decline in their quality of life to live as long as possible may be in violation of the Constitution. Evidence of this changing perspective can be seen in the recognition of Passive Euthanasia and the acceptance of both Advance Directives and Living Wills, both of which show the Courts' growing recognition of Patient Autonomy and the continued evolution of the laws regulating this area of law.

Nonetheless, the issue continues to remain unresolved. Ethical and practical concerns around the issue keep coming up. The potential for someone to take advantage of the situation cannot be discounted, particularly when there is financial pressure on families or there may have already been an erosion of voice of the patient. This is not an abstract concern in India. However, there is no clear statutory framework to guide action, therefore much is based on the judgement of the court or the physician making a decision at the time. As such, both the physician and the family are left trying to determine where they stand on a matter that is uncertain.

Against this backdrop, the paper attempts to unpack the meaning and constitutional grounding of the right to die, while tracing how the judiciary has approached it over time. It also looks at recent developments, not simply to describe them, but to ask whether the current approach really strikes a fair balance between dignity, autonomy, and broader social concerns.

1.1 Types of Euthanasia

Euthanasia can be classified on the basis of both the **nature of the act** and the **consent of the patient**, reflecting its complex legal and ethical dimensions.

1. Based on Nature of the Act

- **Active Euthanasia**

Direct euthanasia is typically interpreted as a direct and intentional act to cause death to someone (by means of a lethal injection or high doses of medication). Direct euthanasia would appear to be a simple, clear-cut act because it is intended to end a person's life as soon as possible and relieve many people who have been suffering from very long-term, very severe pain. While on the surface this act appears to be one of compassion, there is no legal basis in India for providing this type of law to exist. In India, direct euthanasia has no legal basis under criminal law and is strictly viewed as a crime. Culpable homicide should be understood as being a criminal act that is equivalent to committing an unlawful act (homicide). Culpable homicide can occur even if the individual who has died gave consent before the act of culpable homicide happened. The law in India is intended to provide some protection against allowing courts or judges the authority to be involved in directly causing or assisting another person (or entity) to cause death.^[1]

- **Passive Euthanasia**

Passive euthanasia is another form of ending life that occurs in a more indirect and subtle manner. It can be achieved through removal of or withholding treatment that keeps patients alive (like stopping a ventilator or stopping artificial feeding). In passive euthanasia there are no direct actions taken to cause death; rather, death happens as result of the pre-existing conditions a patient is experiencing.

In India passive euthanasia is permitted legally, but only under extremely controlled conditions, such as:-

- Obtaining consent from the patient (or family)-
- Obtaining approval from medical boards-
- Following specific requirements set by law

This form of euthanasia can be thought as being able to allow for a natural death to occur, instead of having an action taken that would cause death.

- **Physician-Assisted Suicide (PAS)**

Physician-Assisted Suicide (PAS) occupies an uncomfortable position in regard to the general subject matter of Euthanasia. PAS is defined as a physician providing assistance to a patient either by giving assistance or aiding in carrying out activities needed by the patient to help them take their own life (prescribing lethal drugs to the patient). The means are provided; however, it is the patient who ultimately administers the lethal dose to themselves. On the surface, the patient's deciding to seek and/or accept assistance might lead one to conclude that it is their decision to end their life via PAS; however, Indian law does not allow PAS as it is considered an act of assisting in suicide under the law. If a physician assists a patient in taking their own life via PAS, they are then liable for providing assistance in the act of committing suicide and therefore creates a distinction from passive euthanasia. There may still be some apprehension that indirect assistance in the act of committing suicide crosses into an area that is outside of the law's ability to establish.

- **Living Will / Advance Medical Directive**

A Living Will is like an Advance Medical Directive (AMD) in that it differs from an AMD in that it allows a person to plan for the future rather than just react to an event at the time. For example, when someone suffers a serious medical condition such as a stroke or goes into long-term unconsciousness, the Living Will will allow them to plan ahead by specifying their wishes for treatment before they are unable to express those wishes. The Living Will provides a person the ability to indicate their choice to refuse or withhold from receiving life-sustaining treatment, specify the circumstances under which they would like to have their treatment withdrawn, and maintain their ability to make independent decisions, even if they're unable to make the decision themselves. In India, the Living Will is legally binding, controlling (i.e., cannot be overridden), and contains several procedural safeguards designed to ensure that the principles of passive euthanasia are achieved, ultimately leading to a Living Will being an effective tool for achieving passive euthanasia, regardless of their limited application today.^[2]

1. Based on Consent of the Patient

Euthanasia can be looked at from the perspective of consent as well, making euthanasia even more complicated than it may already be. There are three main types of euthanasia according to consent: Voluntary, non-voluntary and involuntary. Voluntary euthanasia is probably the simplest type of euthanasia (at least in theory). Voluntary euthanasia is when the patient that is competent (mentally) gives a conscious decision, after being properly informed. The instance of a patient with a terminal illness that has full knowledge of their situation and then chooses not to continue aggressive treatment for that terminal illness is a very good example of voluntary euthanasia. At the same time, the law in India only permits voluntary passive euthanasia under very restrictive circumstances. Therefore, the autonomy exists, but with many restrictions and a measure of control.

Non-voluntary euthanasia introduces uncertainty into the decision-making process because patients who are in a state of severe physical impairment cannot express consent to have their lives ended (for example, due to being in a coma or being in a persistent vegetative state). Typically, family, physicians, and courts make this decision, which sounds reasonable in theory, but may be complicated by family disagreements, hesitancy on the part of physicians, and courts intervening later than expected. On the other hand, involuntary euthanasia is a cut-and-dried issue. An individual is involuntarily euthanised when that person did not agree to die and was capable of making his or her choice at the time he/she died. Therefore, it is not surprising that involuntary euthanasia is considered immoral and is criminal in India, essentially constituting murder under Indian law.

Taken together, these categories show that legality does not depend only on how death occurs, but also on whether genuine consent exists. That is where the real tension lies. Balancing individual autonomy with the need to protect life is not easy, and the law, understandably, proceeds with caution.

1.2 Historical Evolution of Euthanasia

The debate of Euthanasia has been a slow transition from a philosophical basis through clinical medical practice. The first discussion of Euthanasia was with a set of ancient philosophers in relation to how the "just" philosophy of relieving one's misery at all costs can be accomplished

by terminating the patient's life; however, Hippocrates and others considered it unethical. Each side has its own arguments but the growing disparity between the views will continue as technological advancement permits physicians to extend the life expectancy of previously termed "hopeless" illnesses for many months (or many years) after the initial diagnosis or without any realistic expectation of recovering from the original stated illness. Countries like the Netherlands and Belgium have gone so far as to legalize active euthanasia under strict conditions, while the United States has taken a narrower route by allowing physician-assisted suicide in some states. These changes suggest that autonomy, at least in certain contexts, is being taken more seriously.

India's journey regarding end-of-life decisions has been dissimilar to that of many Western countries; this disparity has arisen largely due to differences in legal precedent. Initially, Indian courts placed great emphasis on the idea that "the right to life" is fundamentally important and does not encompass "the right to die." However, this view has become progressively more flexible as Indian courts have begun to understand that "dignity" does not end with death. As a result of these changes, Indian courts have upheld various forms of passive euthanasia and have provided legal recognition to living wills. Together, these developments have helped clarify the meaning of "liberty" in relation to Article 21 (the right to life) of the Constitution of India. Despite these advances, however, there still remains an overall sense of trepidation associated with entirely abandoning the sanctity of life principle.

What has emerged instead is a kind of balance, an attempt to acknowledge that forcing someone to endure prolonged suffering may undermine their dignity. The evolution, then, is not a clean break but more of a careful adjustment, trying to reconcile ethical discomfort with constitutional values.

2. Constitutional Framework

The constitutional debate on euthanasia in India really begins with Article 21 of the Constitution of India. On paper, it guarantees the right to life and personal liberty, which sounds straightforward enough. Yet over time, courts have stretched its meaning well beyond mere survival. Life, they have said, must carry dignity, some sense of well-being, even a certain quality. Once you accept that, a slightly uncomfortable question follows. If dignity is central to life, does it also shape the way one is allowed to die? Early judicial responses were quite firm in rejecting that idea. The courts drew a clear line, insisting that Article 21 could not include a right to end one's life. The Supreme Court made it very clear in their opinion that the constitution did not provide for a constitutional right to end one's own life. However, in cases such as **Gian Kaur v. State of Punjab**[\[3\]](#), the interpretation of the constitution began to change. The Supreme Court made it clear that there is no constitutional right to die, but dying with dignity could be interpreted to be a constitutional right based on Article 21 in cases of terminal illness. Although this is a very subtle difference, it has great significance because it leads to a separation between an unnatural death from a dignified death.

From then on the dialogue continued to evolve, with the courts beginning to shift to ideas and principles surrounding autonomy and personal choice. They began to articulate in their decisions that people should have some level of control over their own bodies and how they make medical decisions. This idea is especially significant and important in a hospital

environment where the decision of whether to continue or discontinue medical treatment for someone is not an easy one to make or figure out. In addition to these evolving ideas concerning individual autonomy, the recent judgment in the **K.S. Puttaswamy v. Union of India** [4] case granted privacy under Article 21 of the Constitution, recognizing privacy as one of the basic rights. The decision created a link between bodily autonomy and the right to make decisions concerning one's body at the terminal stages of life. Presumably, if a person has the right to make personal decisions regarding their individual lives, it is reasonable (although, probably debatable) to assume that choosing to refuse medical treatment would be a part of those same rights.

Even so, the idea is not without limits. The right to die with dignity is not treated as the opposite of the right to life. Instead, it is cautiously framed as an extension of it, shaped by dignity, autonomy, and the need for careful regulation.

2.1 Evolution through Case Laws

(A) Early Judicial Position

Until the case of **P. Rathinam v. Union of India** [5], the judicial view of the right to die or euthanasia had been uncertain and at times contradictory with regard to the interpretation of Article 21 of the Constitution of India. As part of the review of the constitutionality of the provisions of Section 309 of the Indian Penal Code, which punishes a person for making an attempt on their own life, the Supreme Court evaluated whether the restrictions imposed by this section were justifiable as a penalty to persons who had attempted to take their own lives; and concluded that punishing a person who had already reached the point of an attempted suicide was both unreasonable and unjustified. The Supreme Court then went on to state that the right to live could also include the right not to live (i.e., to die). That reasoning leaned heavily toward personal autonomy. It almost treated the decision as an individual choice rather than a matter for the State to regulate. Still, even at that stage, the idea felt unsettled, as if the law itself was not entirely comfortable with where it had landed.

In **Gian Kaur v. State of Punjab** [6], a Constitution Bench reviewed the decision from **P. Rathinam** and firmly stated there is no right to die as part of the right to life. The Court ruled that Section 309 IPC is valid and that the right to life does not include a right to die as per Article 21 of the Constitution; instead, it protects the right to live. The Court did not completely rule out the addition of a new concept—the right to die with dignity—as being relevant to the question of how one can have a dignified death; however, the Court could only do so by distinguishing between ending one's life and allowing one to be able to die with dignity, which later became significant. It marked a shift, not a complete reversal, but a subtle move from outright rejection toward a more careful acknowledgment of dignity at the end of life [7].

(B) Landmark Euthanasia Cases

The legal position on euthanasia in India did not change overnight. It shifted, rather noticeably, through two landmark judgments that moved the law away from strict prohibition toward a more conditional acceptance of end-of-life choices. The first real turning point came with **Aruna Shanbaug v. Union of India** [8], a case that still feels difficult to read without pausing. It involved a nurse who had remained in a persistent vegetative state for decades after

a brutal assault. The Court was confronted with a question that was not just legal but deeply human. Should life be prolonged indefinitely through machines when there is no real awareness or recovery? For the first time, the Supreme Court allowed passive euthanasia in exceptional cases. On the one hand, however, it took a very balanced and cautious approach toward medical termination of pregnancy. Strict procedures were established for medical termination of pregnancy under Article 226, requiring the High Court's approval as well as a physical examination by a panel of qualified doctors. The Court made it clear that the decision must be made only for the "best interests of the patient" and not simply for the convenience of family members. The request for permission to terminate this pregnancy was ultimately denied; however, the reasoning in the decision will provide the basis for future developments..

A few years later, the approach became more confident, perhaps more grounded in constitutional reasoning. In **Common Cause v. Union of India**^[9], a Constitution Bench took a clearer stand by recognizing that the "right to die with dignity" forms part of Article 21 of the Constitution of India. This was not a small step. It reframed the conversation entirely. The Court pointed out that forcing someone to continue life-sustaining treatment against their will could violate their dignity and personal liberty. One of the more practical outcomes of this judgment was the recognition of Living Wills or Advance Medical Directives. These allow individuals to decide in advance how they wish to be treated if they become incapable of expressing consent. Although there are many procedures in place to help protect against fraud or abuse such as medical boards, verification processes, and audits of the authenticity of patient information. In contrast, medical decision making and the autonomy of patients were relied upon more than court approval when comparing to Aruna Shanbaug.

Combined, the two decisions illustrate the slow evolution of Indian law away from a more rigid judicial structure towards a model based on individual autonomy; albeit with considerable judicial oversight/ regulation. The expansion of passive euthanasia through Aruna Shanbaug v. Union of India was accompanied by care, measures and checks and balances and, through Common Cause v. Union of India, had now been firmly placed (at least in law) on the foundation of dignity, privacy and self-determination. Nevertheless, the left-right balance between the two concepts still appears fragile; the judiciary seems to be attempting to protect the sanctity of life whilst simultaneously recognising that an individual's right to live with dignity is equally important as the right to die with dignity, in some circumstances..

(C) Recent Judgments and Developments

The recent phase of euthanasia jurisprudence in India is marked by a transition from judicial recognition to **practical execution and procedural refinement**. The Supreme Court and policy frameworks have increasingly focused on making the right to die with dignity not just a theoretical right but a **workable reality**, while maintaining safeguards against misuse.

- **2023 Modification in *Common Cause***

The case of **Common Cause v. Union of India (2023 amendment)** represents an important step forward. This case marks the Court's reconsideration of its decisions from 2018 and successfully addresses a significant practical barrier that had been created by the prior

requirement for living wills to be executed before a Judicial Magistrate of the First Class. In practice, this made it difficult or impossible for most people to execute a Living Will, as very few individuals (given the large number of persons aged 65 and over) possessed the willingness or ability to navigate through this process. To make it easier for individuals aged 65 and over to execute Living Wills in the future (and provide increased access), the Court relaxed this requirement and allowed Living Wills to be witnessed by either a notary or a gazetted officer. While this may seem like a minor modification to the rule, it will actually create a substantive change in the overall accessibility of Living Wills..

According to the Court's opinion, the medical board process has been simplified, as there were often many layers of approval for a decision from the medical board which could often lead to delays in decision making in very urgent medical situations. The Court has simplified the process for hospitals to establish their medical boards and where to find advance directives to help reduce uncertainty. The Court's intent was to create a more patient-centered approach by acknowledging that too many procedural obstacles can diminish the very autonomy the law seeks to protect. Ultimately, simplifying the process raises concerns about whether the protections for the patient can still provide adequate safeguards.

- **2024 Draft Guidelines on Withdrawal of Life Support**

The Draft Guidelines on Withdrawing Life Support 2024 seem to apply principles from courtrooms to how hospitals function in reality. In the past, many of the laws regarding euthanasia have been made through court decisions, which are valuable but often difficult to implement on the hospital floor at two a.m. These guidelines attempt to develop a more consistent structure across India for making end-of-life decisions. A primary aspect of these guidelines is for the ethics committee in each hospital to have responsibility for approving all treatment withdrawal decisions, while also making sure the process is not done too quickly, and that ethical principles and patient preferences have been considered when making a decision. In theory, this adds a layer of accountability.

The guidelines also address practical challenges such as:

- Proper documentation of consent
- Clear communication between doctors and family members
- Timely constitution of medical boards
- Standardization of procedures across institutions

All of this suggests an effort to close the gap between legal doctrine and medical practice. Still, there are lingering concerns. Not every hospital has the same resources or trained personnel, and differences between public and private healthcare settings could affect how uniformly these guidelines are followed.

- **2026 Supreme Court Decision – *Harish Rana Case***

A development that is new and significant is **Harish Rana v. Union Of India**.^[10] This case is significant because it took what had previously been described in terms of guidelines and used the principles to make a decision. The previous cases had discussed principles and in many

cases had discussions of the principles in a very detailed manner; this case illustrates what happened when the principles were utilized. The Supreme Court permitted the withdrawal of life-sustaining treatment for an individual that was in a persistent vegetative state; however, the Court made it a condition for the withdrawal that all procedural safeguards were followed. It is easy to imagine that this decision carries with it an emotional weight for everyone who was involved in this process, not only from a legal perspective, but from an emotional one.

The Court re-emphasized the fact that there is a legal right to die with dignity as guaranteed under Article 21 of the Constitution of India, which is now an almost universally accepted principle of law. The court also emphasized that "the best interest of the person" must determine what actions will be taken on behalf of that person and how those actions will occur, using medical opinion as well as the prior wishes of that person whenever possible as evidence to support decisions made regarding their care. However, the Court also expressed concerns regarding a lack of a legislative framework for this area of law and, therefore, relying solely on judicial guidelines may yield inconsistent results between different cases..

An overview of the various stages shows that together they give a sense of a gradual evolution over time. The original recognition stage occurred initially (approximately 2018). The simplification of the procedural hurdles occurred in 2023 to reduce the procedural hurdle of creating institutional support from guidelines as of 2024; i.e. create actual institutional support, based on actual experience from cases like of Harish Rana. Thus the beginning of creating the actual framework will be coming together slowly and perhaps in an unstructured manner. They all have a common focus to try and create a balanced approach in apply both autonomy, medical ethics and legal buffer between them with respect to how that balance can be achieved through actual implementation remains to be seen..

3. Statutory Framework in India

The statutory framework governing euthanasia in India is primarily shaped by criminal law provisions, mental health legislation, and policy recommendations, reflecting a cautious approach that prohibits active intervention in death while gradually recognizing patient autonomy in end-of-life decisions.

3.1 Bharatiya Nyaya Sanhita, 2023 and Criminal Liability

The legal definition of euthanasia under the Bharatiya Nyaya Sanhita, 2023, remains extremely valid. Criminal acts of euthanasia regardless of whether or not the victim has provided prior consent are still treated as murder or as related to murder, which allows very little exception for individual circumstances. It is also important to consider that assisting or aiding another in committing suicide constitutes a crime as well, meaning that assistance from doctors or others will always make the doctor or anyone else liable for such assistance. This makes it very difficult for someone to engage in physician assisted dying in India. Reasoning behind the law still appears to be primarily pro-life, regardless of the specific challenges that might exist.

3.2 Section 309 IPC and Its Changing Interpretation

Section 309 of Indian Penal Code (IPC) used to have a very harsh view on attempted suicide. It treated it as a criminal act - similar to committing an act against the State. I think that view

today seems disconnected from reality. A person attempting suicide is almost always not really doing so out of free will in the same way that most people would look at free will. As time has gone on, the rigid view has softened. Courts and those making laws have begun to recognize that these people generally are experiencing severe emotional or psychological stress, not to mention most people who attempt to commit suicide have a mental illness but are unaware they have one. While this law, in theory, still exists, in practice, the application of this law has greatly lessened.[\[11\]](#)

With the implementation of the Bharatiya Nyaya Sanhita, 2023, Section 309 of the Indian Penal Code had a substantial normative change. The new framework under the BNS shifts away from outright criminalization and more closely coincides with a welfare-oriented attitude, whereas the IPC clause classified attempted suicide as a penal offense, reflecting a predominantly deterrent and moralistic stance. This shift is also in line with advancements like the Mental Healthcare Act of 2017, which assumes that someone trying suicide is under a lot of stress and should therefore receive treatment and rehabilitation rather than punishment.

Although traces of liability may still exist in specific contexts, the broader legal position now indicates a shift toward decriminalisation and recognition of mental health concerns, thereby reinforcing the constitutional emphasis on dignity under Article 21.

3.3 Mental Healthcare Act, 2017 (Progressive Shift)

The Mental Health Care Act, 2017 represents a much greater and more significant change in mental health legislation in India. Section 115 of the Act creates a presumption that any individual who attempts suicide is suffering from "severe distress" such that he or she should not be punished under Section 309 of the Indian Penal Code without clear evidence to the contrary. While this may appear to be only a technical change, it represents a major change in the underlying philosophy of mental health laws in India. As a result of this change, the emphasis has shifted from punishment to care, treatment and rehabilitation. In this sense, the Act also establishes the State's duty to provide for the provision of mental health services. In terms of euthanasia, this change in the law is important because it acknowledges that many decisions regarding life and death are not purely rational or voluntary decisions, but rather involve a psychological component that must be considered.[\[12\]](#)

3.4 Law Commission of India – 241st Report

The Indian Law Commission's 241st Report has added further complexity to these discussions surrounding passive euthanasia, specifically that patients have a right under the law not only to refuse requested medical treatment that would prolong their life, but that they do possess that right even if the refusal may ultimately lead to death. The rationale for this distinction is that while both results appear similar (the patient remains alive), allowing a patient to refuse medical intervention does not constitute the "active" termination of a person's life. Additionally, the Report indicates that providing death through passive methods should be accomplished while ensuring there are sufficient safeguards against patients suffering from unnecessary harm through denial of treatment. While the Report does not provide simple solutions to these issues, it does indicate that a more equalized method of euthanasia exists that

protects a patient's right to autonomy and dignity as well as the patient's right to make informed decisions.

Overall, the statutory structure as created by Indian law appears to have two paths - the requirement that criminal law as per Bharatiya Nyaya Sanhita, 2023 continues to prohibit both active euthanasia and assisted suicide firmly; and because of recent developments such as with the Mental Health Care Act, 2017 and the Law Commission's recommendations there seems to be a slow gradual movement towards some compassion and autonomy. Nevertheless, the tension between these two positions remains unresolved. This could also be the reason for the continued lack of a specific comprehensive piece of legislation, which leads to confusion and ambiguity surrounding the issue regarding both dignity and the protection of life.

4. Human Rights Perspective

The dialogue surrounding euthanasia has expanded significantly beyond the criminal code's prohibition or allowance of it, and now incorporates human rights language as well as more of an individual basis for individuals to express their rights. Human rights, dignity, autonomy, and freedom from suffering have all been included and are often regarded as somewhat of a priority. The concept of dignity includes the right of individuals to live, and potentially die, with dignity; this has been acknowledged by the courts as having been included under Article 21 of the Indian Constitution. The value of dignity raises somewhat complex issues for humanity, including whether or not a person should have to endure intense pain or be forced to rely on total independence when there is no chance for recovery.

Freedom from needless pain/dignity is highly related. In today's world, medical technology can do many unique things. It can also prolong life but sometimes in a mechanical/ceremonial way instead of just a ceremonial way (e.g., someone being kept alive for many years on life support without any contact/awareness). To one person, that may represent the availability of life. To another, it may represent extending the experience of life. From a human rights standpoint, forcing the continuation of life through medical technology would violate the enjoyment of a person's human rights rather than protecting them. Thus, in carefully determined circumstances, the removal/deactivation of life support will be viewed as the natural progression to extinguishing/discontinuing life rather than the ending of life itself.

Consent to medical procedures/operations is based on two main components: the individual's right to autonomous decision-making (autonomy) and right to have all possible outcomes given to him/her in order to help him/her make an informed decision (informed consent). Living wills and advance directives create a way for individuals to express their preferences and establish standing orders, prior to losing the ability to make such decisions themselves (or to communicate them).

Euthanasia as a human rights dilemma does not have an easy resolution; it will go in several different directions simultaneously. On one hand is the idea of dignity, freedom of choice, and relief from pain and suffering; on the other hand are serious concerns about misuse, particularly in a society where there are many different ways people could be considered vulnerable. Therefore, the human rights approach does not call for unregulated euthanasia but instead,

supports a system that is designed in a cautious and regulated manner to allow for individual choice while protecting life. Ultimately, the premise of the human rights approach appears to be that a person's right to choose to end their life must be respected, but that those decisions should be made with compassion and dignity..

5. Issues and Challenges

Even with some successful steps taken toward recognizing the right to die with dignity through progressive rulings, legal, ethical, and practical obstacles still remain before the implementation of euthanasia in India. Thus, a cautious approach along with regulations will be necessary in addressing these problems.

- **Scope for Misuse**

Immediate concerns regarding euthanization relate to its "misuse", as we generally agree that there are chances that patients' well-being may not be the focus of the decision-making process in some instances and there may be many other factors influencing these decisions such as property disputes, financial strain of ongoing treatment, or simply caregiver fatigue. The threat of this potentiality would make an already anxious legal system more anxious about the current state of affairs.

- **Vulnerable Groups and Coercion**

There is a connection between vulnerable populations and the areas of concern as it relates to this issue. Vulnerable populations consist of those who may not always be able to say what they want; they may include people who are elderly, have a disability or are economically disadvantaged. As a result of these variables, vulnerable populations may or may not feel pressured to make decisions based on subtle cues versus overt cues. For example: a patient may decide to stop treatment because they view themselves as a burden to their family or that continuing treatment will create financial hardship for the patient's family. Therefore, the patient in these two types of examples makes a decision that they believe is voluntary, although many times, outside forces will have affected the decision-making process of the patient. The primary principle discussed within the legal system that pertains to vulnerable populations is identified as "autonomy;" however, the legal definition of autonomy is not always practically enforced for vulnerable populations.

- **Absence of Comprehensive Legislation**

Lack of comprehensive statutory framework is a further difficulty in the euthanasia field; currently much of euthanasia law consists of judicial pronouncements and changing guidelines rather than a concrete, codified law. This creates many different interpretations of procedures by hospitals and different interpretations of similar cases by courts. For physicians and families already experiencing emotional turmoil, this lack of definition adds to the challenge of making the right decision.

- **Practical Difficulties in Implementing Living Wills**

Despite having legal documents that help individuals express their wishes beyond their capacity to verbally agree (living wills) or express them through written directions (advance directives), implementing those wishes has not been without problems. A person may not know about the

existence of the document, or may have completed one but when he/she goes to a hospital, staff may be reluctant to honor the document for several reasons. Is it a legal document?, Did the patient comply with the procedures necessary for the document to be legally effective?, If they don't follow the document will the staff be liable in a lawsuit? All of these issues can slow down decision making, and all of these problems can become very frustrating in a real-time hospital environment when fast decisions have to be made in order to provide a prompt and proper hospital service..

- **Role of Medical Boards and Judicial Oversight**

Medical boards and courts give additional complexity. The system of medical boards and courts is intended to function as security devices and should typically be part of the process of ending the patient's suffering with grace and exemplary competence. However, all of these processes take a considerable amount of time to form a board, consult with experts, and complete legal requirements, so there is some risk that the time involved in the process could result in the death of the patient before the time needed to provide for a dignified death is available.

- **Ethical Conflict Between Family, Patient, and Physicians**

Then there are the ethical tensions that arise between patients, families, and doctors. A patient may wish to discontinue treatment, while family members struggle to accept that choice. Doctors, trained to preserve life, may find themselves conflicted when asked to withdraw support. Cultural and emotional factors often deepen these disagreements. What seems like a clear decision in theory becomes far more complicated when real people and relationships are involved.

Taken together, these challenges show that while euthanasia has gained some degree of legal recognition in India, its practical application remains uneven. Risks of misuse, limited awareness, procedural delays, and ethical conflicts all play a role. Addressing them will likely require not just clearer laws, but also stronger safeguards and a more informed public conversation, so that the idea of dying with dignity does not lose its meaning in practice.

6. Need for Comprehensive Legislation

The Euthanasia laws currently exist in India within a framework that relies on the judicial system rather than established statutes; this reliance on the judicial branch, while warranted due to the evolution of euthanasia law, leaves a lot of room for ambiguities. The courts have recognised the right to die with dignity under Article 21 of India's Constitution, but applying this principle to daily life (i.e., making decisions regarding medical treatment) can be very difficult for those working in busy ICUs or for families who are making difficult decisions. Therefore, the need for a comprehensive, fully detailed euthanasia statute in the Country is very important; there is little debate about whether or not it should exist, but rather about how much it will affect individuals' lives. Additionally, without a complete euthanasia statute, there continues to be confusion regarding how to approach the treatment of patients who wish to have their issues resolved through euthanasia.

The development of a formal legal framework regulating euthanasia or end-of-life care would alleviate some of the ambiguity associated with these types of cases. A legal framework may define what constitutes active euthanasia and what constitutes passive euthanasia; when the decision may be made to discontinue life-support; and define and delineate the parties to the process (e.g., physician(s), patient's family) who are to be included in the process. Reliance upon judges to make decisions on a case-by-case basis in such cases to provide a more uniformly consistent experience may be simpler, but many would argue that there are also benefits that accrue to the system for the flexibility associated with the current system. The question of advance directives (also known as living wills) should also be resolved. Although, in most instances, courts have recognized such documents, the creation and execution of advance directives do not require statutory authorization and may be completed in an unregulated manner. As a result, implementation of advance directives may not be uniform among the differing jurisdictions. The regulation of advance directive creation, execution and validation through a statutory framework would create uniformity in completing advance directives. Imagine a situation where a patient's wishes are written down but later questioned because the procedure was unclear. That kind of ambiguity can be avoided with clearer rules.^[13]

If implemented, any law requiring a regulated procedure must contain appropriate safeguards. This means that safeguards must be built into the evaluation of the patient by the medical boards; informed consent must be provided by the patient, and independent verification must be established that will ensure that the law is being used correctly. However, there must be a balance between having enough safeguards so that they do not hinder access to the regulated procedure and having enough safeguards that they do not create complications or long delays in reaching a decision, which may be time sensitive.

Implementation of the law will be equally important as the law itself. Implementing regulatory mechanisms, such as organizational ethics committees and regulatory authorities, will help maintain consistency and hold accountable in making the correct decision as intended under the law. Implementing these types of systems will not be mere bureaucratic arrangements; rather, they will have the capacity to establish how decisions are actually made and carried out at the local level. However, the effectiveness of these systems will be dependent on how effectively they operate in practice.

Finally, broader reforms would need to support any legal framework. Public awareness about patient rights, better training for healthcare professionals, and stronger palliative care services all play a role. Without these, even the best law might struggle to achieve its purpose. In the end, the goal seems to be a system that respects autonomy while remaining sensitive to the risks involved, a system that takes dignity seriously, not only in life, but also in the way it comes to an end.

Conclusion

The process of implementing euthanasia in India has reflected a slow, but ultimately evolving and sometimes strained, evolution of our Constitution. Initially, from a narrow interpretation of the right to life, over the decades, it has now developed into being more sophisticated, and likely a more humane, response to an individual's right of choice for their own dying. The legal

source of this change can be traced back to Article 21 of the Indian Constitution. When initially suggested by the courts, the interpretation of Article 21 did not seem to include an individual's right to choose death (as well as being able to die with dignity). However, over the years the judicial interpretations have accepted the position that an individual's dignity is inseparable from their right to life, and is inclusive of the process to die, so therefore it must also have an impact on the manner in which one can die. Landmark decisions helped draw a distinction between unlawfully ending life and allowing the withdrawal of life-sustaining treatment in cases where suffering is irreversible. The shift is subtle but meaningful. It moves away from a rigid insistence on the sanctity of life toward a more balanced view that also considers the quality of life.

Nonetheless, recognition of a right to die with dignity leads to additional problems. While autonomy is simple enough in principal, it is much less clear cut in practice. A patient's decision must truly be theirs alone, and must not be subject to any sort of pressure from family, monetary status or any sort of subtle expectation. This then makes clear the importance of safeguards. Medical boards, formalised processes and the application of ethical scrutiny are more than mere formality; they are to provide an assurance to those who are already in a vulnerable position. It will remain a balance of individual freedom and social responsibilities in terms of preventing abuse or misuse, and maintaining ethical standards in the practice of medicine. Finding this balance will not be an easy exercise and may continue to be a challenge for the law for many years to come.

Looking ahead, the most effective way to address these complexities is through comprehensive legislative reform. The absence of a clear statutory framework continues to create uncertainty and reliance on judicial guidelines. A well-defined law on euthanasia and end-of-life care would provide clarity, uniform procedures, and stronger safeguards while reinforcing the constitutional commitment to dignity and personal liberty. Therefore, the future path lies in developing a balanced legal framework that integrates compassion, autonomy, and regulation, ensuring that the right to die with dignity is exercised in a responsible and humane manner.

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