RIGHT TO LIFE AND RIGHT TO DIE: POLICY ON EUTHANASIA IN INDIA

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ABSTRACT

This paper analyses the developing jurisprudence about euthanasia in India in the context of the fundamental right to life and personal liberty under Article 21 of the Constitution of India. The paper traces the judicial trajectory from the judgement of the Bombay High Court in State of Maharashtra v. Maruty Sripati Dubal (1987)[1] to the Supreme Court judgements in Aruna Ramchandra Shanbaug v. Union of India (2011)[2] and Common Cause v. Union of India (2018)[3] and Common Cause v. Union of India (2023)[4].

The paper adopts both comparative and doctrinal avenues coupled with constitutional jurisprudence and selected foreign models to evaluate whether the current model of euthanasia jurisprudence is sufficient or not. The paper argues that while passive euthanasia has been recognised and proceduralised by the judiciary, active euthanasia is still criminalised under the Indian statutory law. The paper argues that the existing judicial precedents, without being enshrined in legislation, do not provide the requisite regulatory structure in India to adequately protect individual autonomy and the public interest.

The paper, through a comparative analysis of the euthanasia regulatory frameworks in the United Kingdom, the Netherlands and Luxembourg (these countries have been chosen for their varied regulatory philosophies ranging from terminally cautious to permissively physicianassisted to intermediate models), identifies the procedural and substantive gaps in India's approach and proposes a series of actionable legislative and policy proposals, including the establishment of a Regional Review Committee along the lines of the Dutch model, compulsory psychiatric evaluation, time-bound approval processes, public disclosure mechanisms, and mental health support for the families of patients and healthcare professionals. The paper arrives at the conclusion that a codified policy on euthanasia would be beneficial in the Indian law if there are proper safeguards against unfair practices such as, abuse or undue influence.

Keywords: Euthanasia, Article 21, comparative law, right to die, medical law, India.

[1] State of Maharashtra v. Maruty Sripati Dubal, 1987 Cri. L.J. 743 (Bom. H.C.) (India).
[2] Aruna Ramachandra Shanbaug v. Union of India, (2011) 4 S.C.C. 454 (India).
[3] Common Cause (A Regd. Soc'y) v. Union of India, (2018) 5 S.C.C. 1 (India).
[4] Common Cause v. Union of India, 2023 SCC OnLine SC 373 (India).

Hypothesis

Indian law on euthanasia is not concrete enough as it is only based on judicial precedents rather than a codified policy on the same.

Literature Review

There are three important themes that can be derived from the assessed academic literature on euthanasia:

1. The international law's stance on end-of-life care policies.
2. Influence of other disciplines, such as religion.
3. The current challenges that euthanasia faces in India.

Lee (2023)[5] provided South Korea's stance on euthanasia and emphasised the importance of judicial legislation before any concrete policy decision. Here, other disciplines such as ethics, medicine and law can be particularly useful in formulating a law on euthanasia or end-of-life care. Cheung and Dunn (2023)[6] compared various Asian jurisdictions and showed how certain religions or cultures affect the policy making on the subject. These are important to also understand that a codified law on euthanasia should be approached with an interdisciplinary outlook rather than solely basing it on law or ethics. This interdisciplinary outlook has provided certain essentials for administration of euthanasia, such as, informed consent, oversight mechanisms and assessment of the patient. Singh (2024)[7] identifies a fundamental constitutional tension in the Supreme Court's approach to the theme of Indian jurisprudential ambiguity: while the Court routinely affirms bodily autonomy as a constitutional value under

Article 21[8], it simultaneously refuses to extend that right to active euthanasia, which it treats as incompatible with both public policy and existing criminal law. Singh's work is especially incisive in finding this contradiction within a human rights framework, with reference to the unaddressed tension between the criminalisation of active euthanasia under the Bharatiya

[5] Myung Ah Lee, Ethical Issue of Physician-Assisted Suicide and Euthanasia, 26 *J. Hospice and Palliative Care* 95 (2023).
[6] David Cheung and Michael Dunn eds., *Advance Directives Across Asia: A Comparative Socio-Legal Analysis* (Cambridge Univ. Press 2023).
[7] Hitendra Singh, Amita Rathi and Mayank Dubey, *Euthanasia and the Countries Which Positively Regulated Active Euthanasia,* 12 J.L & Sustainable Dev. e04047 (2024), https://doi.org/10.55908/sdgs.v12i10.4047.
[8] India Const. art. 21.

Nyaya Sanhita and the Court's expansive interpretation of the right to die with dignity. Singh's analytical study complements this by bringing to the fore the procedural lacunae that continue to plague India's passive euthanasia framework, especially the delays in the implementation of advance medical directives. Building upon these contributions, this paper examines the procedural frameworks of three carefully selected comparative jurisdictions, the United Kingdom, the Netherlands, and Luxembourg, and proposes how their best practices may be adapted for the Indian legislative context. There are two limitations of the paper. Firstly, this paper does not morally assess the practice of euthanasia itself but making its procedural requirements holistic and concrete. Secondly, the paper only considers euthanasia administered to adult patients.

Introduction

"Euthanasia" finds it origins from the Greek words *eu (*good) and *thanatos* (death), which translates to a "good death." The term itself means ending a person's life at their request to relieve them of any terminal illness or any incurable condition. The concept is widely debated amongst the medical and legal disciplines and questions the extent of individual autonomy and raises ethical dilemmas as well.

Euthanasia is divided into two main types: active and passive. Active euthanasia is the deliberate administering of a lethal substance or act (e.g., lethal injection) at the explicit request of the patient with the explicit intention of ending that patient's life.[9] Passive euthanasia is the withdrawal or withholding of life-sustaining treatment (e.g., removal of a ventilator or cessation of artificial nutrition), allowing the patient to die naturally from his or her underlying condition.[10] There is also a distinction between voluntary euthanasia, in which the patient expressly and competently consents to the termination of the patient's life, and non-voluntary euthanasia, in which the decision is made by an authorised third party on behalf of the patient who is unable to communicate the patient's wishes, for example, an individual in a permanent vegetative state (PVS). Euthanasia is sought only in the case of incurable, terminal or degenerative conditions causing sustained and irremediable suffering.

The legal landscape surrounding euthanasia in India is defined entirely by judicial precedent rather than codified legislation. Active euthanasia is still a criminal offence under Bharatiya

[9] Shanbaug, (2011) 4 S.C.C. 454, para 38.
[10] *Id.*

Nyaya Sanhita (BNS), specifically under Sections 100[11], 101[12] and 108[13] and its predecessor, Indian Penal Code (IPC) under Sections 300[14], 306[15] and 307[16], both of which equate the practice with culpable homicide and murder. Passive euthanasia, however, has been progressively recognised by the Supreme Court of India as a constitutionally permissible exercise of the right to die with dignity under Article 21 of the Constitution. The Supreme Court ruled in Gian Kaur v. State of Punjab (1996)[17] that the right to life under Article 21 does not include an absolute right to take one's life, but the right to die with dignity has been developed incrementally in case law. But the existing euthanasia regime in India is fragmented and judgemade and needs legislative codification for consistent and fair application. This paper critically examines the evolution of India's euthanasia jurisprudence, contextualizes it within its philosophical and religious milieu, and draws upon comparative frameworks from the United Kingdom, the Netherlands and Luxembourg to develop concrete policy recommendations for prospective Indian euthanasia legislation. This paper has chosen three countries to assess, namely, The Netherlands, The United Kingdom and Luxembourg. By combining the legislations of these three countries, we can get a proper picture of how a policy governing such a sensitive subject matter should be formulated. Firstly, The UK is focused on terminally ill patients with proper judicial oversight. Secondly, Luxembourg provides a median ground as it is liberal than UK's model but stricter than Netherlands. Lastly, Netherlands, have the most complete model out of the three, where both active and passive euthanasia are allowed coupled with a proper oversight mechanism. Together, they provide a spectrum of approaches from which India can derive useful insights.

The example of South Korea is instructive in this regard. The Supreme Court in the Kim (Severance) Hospital Case[18] in 2009 upheld passive euthanasia, showing that even traditionally conservative Asian jurisdictions have found workable legislative solutions; a path that India would do well to consider. The example of South Korea is not cited as a comparative jurisdiction but to highlight that even traditional, conservation and non-western legal systems have found it permissible to recognize passive euthanasia. This tolerance makes India's

[11] Bharatiya Nyaya Sanhita, 2023, § 100 (India).
[12] Bharatiya Nyaya Sanhita, 2023, § 101 (India).
[13] Bharatiya Nyaya Sanhita, 2023, § 108 (India).
[14] Indian Penal Code, 1860, § 300 (India).
[15] Indian Penal Code, 1860, § 306 (India).
[16] Indian Penal Code, 1860, § 307 (India).
[17] Gian Kaur v. State of Punjab, (1996) 2 S.C.C. 648 (India).
[18] Severance Hospital Case, Case No. 2008Hun-Ma385 (Const. Ct. Nov. 26, 2009) (S. Kor.).

legislative silence on the subject matter a bit more glaring. Hence, this paper will analyse Indian jurisprudence on euthanasia and will try to formulate proper regulatory and policy proposals, based on a comparative analysis with The Netherlands, Luxembourg, and The United Kingdom.

Philosophical Debates on Euthanasia

To understand the divergent legal positions adopted by different jurisdictions, including India, it is necessary to understand the philosophical basis of euthanasia. Three schools of thought dominate the discourse – Utilitarianism, Deontology and Virtue Ethics. These three schools of thought are specifically chosen because most of the normative decisions about end-of-life care are based on these. For instance, the Common Cause (2018) decision reflected a contrast between autonomy, which is based upon utilitarianism and sanctity of life, which is based upon deontology. Utilitarianism, which looks to the happiness or well-being produced by an action, supports euthanasia as a means of alleviating irremediable suffering.[19] It believes in reducing pain which is irredeemable, hence, in a way, it respects the preferences of a patient. Deontology, which looks to the absolute duties and inherent moral rules that govern an action, opposes euthanasia on the basis that human life has intrinsic value which cannot lawfully be extinguished, regardless of the consequences of continued suffering.[20] Now, virtue ethics on the other hand assess the decision-maker, specifically their moral character.[21] According to this school of thought, euthanasia raises questions about the professional integrity as well as the notion of being just. Understanding these schools provides us with a reason as to why the Indian jurisprudence on the subject is focused on balancing individual autonomy with the sanctity of life.

Types of Euthanasia

Euthanasia is of two types – active and passive.[22] Firstly, active euthanasia. Here, the patient themselves requests the termination of their life via any medical intervention. Secondly, passive euthanasia. Here, the patient themselves are unable to communicate and such a decision is made by a family member or acquaintance on their behalf. In passive euthanasia, the patient is unable to communicate their intent due to a persisting medical condition. This distinction is not

[19] James Rachels, *The End of Life: Euthanasia and Morality* (Oxford Univ. Press, 1986).
[20] *Id.*
[21] *Id.*.
[22] Shanbaug, (2011) 4 S.C.C. 454.

legal jargon but particularly important in the Indian context as the Indian courts have explicitly outlawed active and are conditionally assenting towards passive.

The practice is debated heavily and is legislated very differently across various jurisdictions, hence, not having a uniform legal position. For example, Netherlands allow this practice, but India does not do so in its entirety with only passive euthanasia receiving assent from the Supreme Court.

Evolution Through Indian Judicial Decisions

Euthanasia in India is a judge-made law, meaning, it has been shaped by precedents rather than legislations. However, before tracing this evolution, it is important to remember that Indian Courts have outlawed active euthanasia and administering such to a person can be charged as an offence under Bharatiya Nyaya Sanhita 2023 for culpable homicide or even abetment to suicide, even if the victim had requested it themselves. Hence, it is with this background, we must understand why a narrow acknowledge of passive euthanasia came to be.

The following traces this evolution chronologically. The first significant judicial intervention came from the Bombay High Court in State of Maharashtra v. Maruty Sripati Dubal (Bombay High Court, 1987)[23]. The petitioner was a police officer who developed Schizophrenia after an accident and tried to commit suicide due to frustration from the bureaucratic delays. The petitioner was charged with an offence under Section 309[24] IPC and challenged the constitutionality of the provisions. This decision is important in the context of euthanasia as it not only clarified the right to life under Article 21 but also stated that the opposite i.e., the right to die is also a part of it.

Building on this the Supreme Court of India in P. Rathinam v. Union of India (1994)[25] declared Section 309 to be unconstitutional. The Division Bench's decision was that the scope of right to life was expanded to include the right to die if the life a person is currently living is degrading, painful or intolerable. Although this decision was set aside in Gian Kaur case (1996), the argument for a life with dignity was essential for euthanasia jurisprudence in India.

Perhaps the most influential decision in this line of authority is Aruna Ramchandra Shanbaug

[23] Maruty Sripati Dubal, 1987 Cri. L.J. 743.
[24] Indian Penal Code, 1860, § 309 (India).
[25] P. Rathinam v. Union of India, (1994) 3 S.C.C. 394 (India).

v. Union of India (2011)[26]. The case concerned Aruna Shanbaug, a nurse who had been strangled and sodomised in 1973, resulting in severe brain damage and a permanent vegetative state. A social activist, Pinki Virani, petitioned the Supreme Court for permission to withdraw life support on the grounds that continued existence in a vegetative state violated Aruna's right to die with dignity under Article 21. The Court declined to grant the specific relief sought but issued comprehensive guidelines for the administration of passive euthanasia in India. These were the main principles that were shown: Active euthanasia (lethal injection or medication) is not allowed. Only passive euthanasia, the withdrawal of life-sustaining treatment, is permissible in rare circumstances. Passive euthanasia is not a right but a permission that must be obtained from the High Court of the relevant state, upon demonstration of the exceptional nature of the case. A panel of doctors must decide that the patient fits the definition of a permanent vegetative state (PVS). Patients who do not meet the threshold for PVS are not eligible for passive euthanasia. The decision must be made in the best interest of the patient with bona fide consent from a family member or the next friend of the patient. The withdrawal of life support must be witnessed by two persons and signed off by the Judicial Magistrate of

First Class or the hospital medical board. Besides these guidelines, patients have the option of signing Leave Against Medical Advice (LAMA) forms that allow discontinuation of treatment for terminal conditions. These are like the Do Not Resuscitate (DNR) forms in the United States and are based on the principle of bodily autonomy and the right to die with dignity. In practice, these LAMA forms are supposed to be handled with care by the treating physician who must have an informed consent and the form must be signed by a witness.

The constitutional validity of passive euthanasia was affirmed by a Constitution Bench in Common Cause v. Union of India (2018)[27]. The Supreme Court clarified that Article 21 includes a person's right to die with dignity as well. An adult who is of sound mind can provide an advance directive to the treating medical professionals to either withhold or withdraw the treatment in case of any terminal illness. Once a directive is issued, it is to be executed in front of two witnesses and a notary officer. Next, it is to be safely submitted with the District Magistrate and must be provided to the concerned medical board as and when the situation arises. However, the 2018 framework attracted criticism for introducing procedural delays, particularly due to the stringent composition requirements for medical boards (including a

[26] Shanbaug, (2011) 4 S.C.C. 454.
[27] Common Cause, (2018) 5 S.C.C. 1.

mandatory 20-year minimum experience threshold) and the mandatory involvement of a Judicial Magistrate of First Class for each request.

The procedural requirements in the Common Cause (2018) decision led to delays in processing of requests. Specifically, the requirement of 20 years of work experience for the medical board members and the requirement of a signature of a Judicial Magistrate were causing delays. This led to a reference to another Constitution Bench in Common Cause v. Union of India (2023)[28] which streamlined the process. The revised framework reduced the minimum experience requirement for board doctors from 20 years to 5 years, made the inclusion of a Chief Medical Officer on the district medical board a directory (rather than mandatory) requirement, dispensed with the mandatory sign-off by a Judicial Magistrate of First Class to eliminate bureaucratic delays, and imposed a 48-hour deadline for medical boards to decide on the validity of living wills.

More recently, in Harish Rana v. Union of India[29], the Supreme Court allowed passive euthanasia to be administered on an adult patient. The Court confirmed that: the patient was in a complete vegetative state; the parents were acting as representatives of the patient's voice given his incapacity; treatment had been administered for over two years without improvement; the patient was sustained solely by artificial life support; and continued life support would be contrary to natural course and undignified. On this basis, the Court agreed to pass an order allowing passive euthanasia. Here, the Court relied on the principles given in the 2018 and 2023 Common Cause decisions. Here, if a patient is in a permanent vegetative state and their survival is only artificially possible then the patient's family can request for administration of euthanasia, after assessing the necessity of the request.

This progression can be observed in Indian jurisprudence: the first denial of any right to die (Gian Kaur), the decriminalisation of attempted suicide (P. Rathinam), the tentative green light to passive euthanasia (Aruna Shanbaug), and then the refinement of procedural safeguards (Common Cause 2018 and 2023). The judiciary has tried to find a balance between individual autonomy and societal interests in this progression, always limiting the scope of permissible euthanasia to passive euthanasia only.

Upon closer inspection, euthanasia in India is entirely governed by Courts. As seen above, with

[28] Common Cause, 2023 SCC OnLine SC 373.
[29] Harish Rana v. Union of India, 2026 SCC OnLine SC 358 (India Mar. 11, 2026).

each decision, the Court has clarified its stance on the practice. Eventually giving a concrete answer to allow passive euthanasia. However, such a pattern has a few issues. Firstly, since it is a Judge made law, it is vulnerable to be more dynamic than a codified legislation with each successive bench. Secondly, the Judiciary is not the prong concerned with lawmaking and that a codified legislation is the Legislature's duty which will aid in navigating and cementing a uniform code for administration of this practice. Hence, in the proceeding section, a comparison with foreign jurisdictions will highlight that a legislation following a judicial recognition is very essential.

Comparative Analysis with Foreign Legislations

Since euthanasia in India is a judge-made law, it is essential to understand how different countries have codified it, to better the current policy framework on the subject.

First, the United Kingdom. The Terminally Ill Adults (End of Life) Bill[30], which passed the House of Commons in June 2025 and is currently being assessed by the House of Lords, holds several provisions of potential relevance to India. The Bill applies only to persons above 18 years of age suffering from terminal diseases with six months or less to live, and requires multiple approvals from the patient, their next of kin and the medical board, ensuring that consent is bona fide and uncoerced. Since one of the primary objections of India to active euthanasia is the risk of coercion by next of kin, the UK's model of mandatory psychiatric evaluation to assess both the voluntariness and the capacity of the patient's decision is directly applicable to the Indian context.

The Netherlands and Luxembourg provide further lessons for India, especially about the mechanisms through which wider forms of euthanasia may be regulated with strong safeguards. The Netherlands regulates euthanasia via the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002[31], allowing both active and physician-assisted euthanasia subject to review by a Regional Euthanasia Review Committee. Which is a decentralised, quasi-judicial mechanism that assesses each case independently rather than routing all approvals through the courts. Here, it is assessed whether the condition of the patient is incurable or intolerable coupled with chances of improvement. Here, the patient is then informed about this prognosis and the consequences of their illness. If no foreseeable

[30] Terminally Ill Adults (End of Life) Bill 2024-25, HC Bill [7] (UK).
[31] Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002, Stb. 2001, 194 (Neth.).

alternative is available, then a second physician is asked to assess the condition. Now, the situation is reported to a Regional Euthanasia Review Committee (RTE) which finally reviews the case.

Luxembourg, regulated by the Law of 16 March 2009 on Euthanasia and Assisted Suicide[32], is comparatively stricter: euthanasia may only be requested where a person experiences severe and irremediable suffering, and requires both dual-physician approval and an independent psychiatric evaluation. A distinguishing element here while comparing to the Dutch system is that if the competency of the patient to make decisions is even remotely in question, then a psychiatrist needs to be mandatorily informed. The Netherlands do not have this safeguard as a mandatory requirement and is only done selectively.

Recommendations for Future Policy Making

This paper began with the hypothesis that Indian jurisprudence on euthanasia is incomplete and requires a stronger normative foundation. The foregoing analysis confirms this assessment. India has indeed made significant judicial progress from the outright rejection of any right to die (Gian Kaur) to the qualified acceptance of passive euthanasia and advance medical directives (Common Cause 2018 and 2023). Since the framework is still entirely judge-made, it lacks the certainty that a written and codified legislation provides. This lacuna makes the law on euthanasia inherently incomplete.

Now, upon comparing Indian jurisprudence with the three comparative models, there are three structural gaps in India's legal sphere. Firstly, India does not have an oversight model and mostly, approvals are court based as well. This creates delays in urgent applications where the patient may suffer from excessive delay. As seen in the Dutch model, a decentralised Review Committee (RTE) can be very efficient in reviewing applications. Secondly, Luxembourg and UK have a mandatory psychiatric assessment of the patient, India lacks this assessment and only the circumstances of the illness are seen. This needs to be mandatory to accurately assess the mental capacity of the patient as well as the extent of voluntariness. Thirdly, India has no system for post procedure support toward the family of the patient and has no mental health resources for the medical professionals who were part of such a procedure. Both things are

[32] Loi du 16 mars 2009 sur l'euthanasie et l'assistance au suicide [Law of Mar. 16, 2009, on Euthanasia and Assisted Suicide], Memorial A, No. 46 (Lux.).

provided in Luxembourg's and Netherlands' models.

Hence, the following which the current jurisprudence has:

1. Transparency – There should be a mandatory registration of living wills, and the ability to access the said wills in a public forum. Not only would it provide a public accountability to the person filing for the said registration but also would allow the people to provide objections towards the registration. One of the arguments in the Common Cause cases was the absence of any public forum to publish reports related to euthanasia. Here, the Dutch system can be inspired from as the RTE publishes annual reports.

2. Oversight – It is essential to have a proper oversight mechanism for a subject matter as sensitive as euthanasia or end-of-life care. An oversight is essential to assess the genuineness of a request for euthanasia and to assess whether such request is born out of undue influence or coercion. Here, the Supreme Court in Common Cause (2018) decision emphasised that a lack of a proper oversight mechanism will breed undue influence in cases of such sensitive nature.

3. Inspiration from foreign legislations – The proposition for regional review committee for India should be based on the RTE as seen in the Dutch Model which works and is set up under the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002. Three important procedural safeguards must be kept in place. Firstly, the committee must show a multi-disciplinary coram. It should be made up of at least one lawyer, one physician and one Administrative Officer. Secondly, a summation of each case must be monthly reported to the Committee by the concerned physician. Lastly, like RTE, the committee must publish an annual report for institutional accountability and public accessibility.

4. Participation of Medical Professional – Another provision which is very necessary in this policy framework is the ability of the medical professional to take part in a euthanasia case or a case where euthanasia is imminent. Here, if the medical professional is not comfortable with taking part in this case, then they should be allowed to not partake. However, if such an option is not available, then proper mental health resources should be provided to that medical professional to deal with the impact of that case. Such a right of medical professionals is derived from one of the principles of Wet op de Geneeskundige (WBGO),

also known as the Medical Treatment Agreement Act.

5. Psychiatric Evaluation of the Patient – Drawing inspiration from the United Kingdom's bill, a proper psychiatric evaluation process should be administered upon the person who is making the request. Here the concerned assessor or the assessment officer should see whether the request is genuine, voluntary, and informed, or is it bound by elements of undue influence, coercion, or familial pressure.

6. Strict Timeline – Bureaucratic delays are a major issue when it comes to assessing and then confirming the requests for euthanasia. Hence, drawing from the 2023 decision on the Common Cause case, there should be a 48-hour timeline to assess and to provide a decision to either accept or reject the application for euthanasia.

In addition to the recommendations, certain phases or procedural stages should also be a part of the policy of euthanasia in India whilst assessing an application. Firstly, Screening phase. It is the initial assessment of the application of the patient and to check whether such an application is necessary and genuine. If an application passes the request, then it is going to move onto the next phase. This is derived from the Dutch model's "due care" criteria (zorgvuldigheidseisen).

Secondly, Psychiatric evaluation. Since the screening phase was primer face, the psychiatric evaluation phase will focus upon the patient or their representatives in case the patient is unable to communicate their desires. Here, a professional, mental health officer or as professional psychiatrist question the patient or the representatives to see whether there are elements of coercion or undue influence whilst submitting or making this application. Moreover, this phase will also be the one where the patient or the representatives will be explained what euthanasia is, and what are the consequences of making this decision. This is also provided in Luxembourg's Law of 2009 and in the proposed UK Bill's Clause 7.

Thirdly, Final approval phase. This phase will be a submission of the aforementioned two phases, and the committee will formally approve the execution or the administration of euthanasia upon the patient. This is derived from the Dutch model, specifically, the functions of the RTE. Fourthly, Post approval arrangements. A proper medical board will be appointed to plan for the procedure. The members of the board will be appointed based on seniority, work, experience, and overall approval in the medical field. This model was also addressed in the

2023's Common Cause decision.

Fifthly, Oversight phase. During the administration of euthanasia and independent witness and an oversight officer, preferably somebody from the judiciary will be present. This was emphasised by the Supreme Court in Aruna Shanbaug's case in 2011. Sixthly, After procedure phase. For all the family members involved and all the friends of the patient upon whom the euthanasia was administered, shall be provided a proper medical aid by a mental health professional to cope and move on with this experience. This is inspired from the bereavement counselling as done in Netherlands.

Conclusion

Euthanasia and its legal nuances are still evolving in India. The judiciary has gone on an evolutionary trip when it comes to the concerned subject matter. Initially, the concept of proper body autonomy was rejected in the Gian Kaur case. However, in 2018 and 2023, the judiciary was completely opposite to what they held in the aforementioned case through the Common Cause judgements. However, since there is only judgement law on euthanasia, it is important that India derives its inspiration from the policy in other countries, such as the ones mentioned in the paper, namely Netherlands or United Kingdom. It is very necessary to provide a balance between bodily autonomy and proper safeguard to exercise the right of bodily autonomy.

Hence, the hypothesis provided during the beginning of the paper stands affirmed. Therefore, the Indian position on euthanasia is still incomplete and is in a dire need of a codified legislation. The Indian Supreme Court has progressively warmed up to the concept of euthanasia but is still hesitant to extend its assent to active euthanasia. Hence, the principle of body autonomy is still different from the ground reality. The evolution of the Supreme Court can be seen by denying this principle in the Gian Kaur case to acknowledging the passive euthanasia in the Aruna Shanbaug case. Lastly, in the common cause cases, the Supreme Court went ahead and provided proper guidelines for the practice of euthanasia to be administered in India. Hence, the court, even though in trying to strike a balance between bodily autonomy and the sanctity of life, is still leaning towards the latter by not providing absolute bodily autonomy to an individual. However, through a comparative analysis with the policies provided by the Netherlands, the United Kingdom and Luxembourg, it is possible for the Indian courts or the Indian legislature to provide a policy, acknowledging the absolute form of euthanasia along with proper procedural, safeguard and a robust oversight mechanism. For instance, the United

Kingdom's mandatory psychiatric evaluation, the Netherlands' concept of regional review committee and even Luxembourg's dual psychiatric assessment. Hence, the paper provided a plethora of policy recommendations on the subject matter of euthanasia in India:

1. Instead of the High Court centric approval, there should be a regional review committee, which assesses the requests for euthanasia.

2. There should be a mandatory, psychiatric evaluation for all the applicants of euthanasia.

3. There should be strict deadlines to assess and to approve or reject a particular application.

4. There should be a public registry and a public propagation of any advanced medical directive or any request for euthanasia for public transparency as well as to invite objections to any application.

5. Lastly, there should be a structured and concrete mental health support for all the family and friends of a patient who has been administered euthanasia.

6. The goal of the policy should be to provide a codified and specific provision-based legislation rather than a purely principle based or judge made law.

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