EUTHANASIA IN INDIA: A STUDY OF INDIAN LAW, MEDICAL ETHICS, AND INTERNATIONAL COMPARISONS

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ABSTRACT

Euthanasia, commonly known as mercy killing, is the act of intentionally ending a person's life to put an end to their pain and suffering, especially when they are terminally ill with no chance of recovery. This paper examines the legal and medical dimensions of euthanasia in India, with a specific focus on how the Indian judiciary has interpreted Article 21 of the Constitution, The Right to Life, to include the right to die with dignity. The paper traces the evolution of euthanasia law through landmark judgements: Gian Kaur v. State of Punjab (1996), Aruna Shanbaug v. Union of India (2011), and Common Cause v. Union of India (2018). It further discusses the ethical challenges faced by medical professionals, the role of the Law Commission of India, and the distinction between active and passive euthanasia. A comparative analysis shows how countries, including the Netherlands, Belgium, Canada, and the United States, have approached legalisation, and what lessons India can draw from these models. The paper concludes that while India has made significant judicial progress, a clear and comprehensive legislation governing euthanasia and end-of-life care is the urgent need of the hour.

Keywords: Euthanasia, Article 21, Right to Die, Passive Euthanasia, Active Euthanasia, Medical Ethics, Living Will, Advance Medical Directive, Indian Constitution, Comparative Law.

1. INTRODUCTION

Every human being wishes for a healthy and long life. However, there are situations where a person suffering from a serious and incurable illness may want to end their life rather than continue living in unrelenting pain. This is where the concept of euthanasia becomes relevant. The word 'euthanasia' is derived from the Greek words 'eu' meaning good, and 'thanatos' meaning death. Together, they mean a 'good death' or an 'easy death.' In simple terms, euthanasia is the practice of mercifully ending a person's life so that they are relieved from unbearable suffering caused by an incurable disease or an irreversible medical condition.

Euthanasia is not a new concept. It has been debated since ancient times in Greece and Rome, where ending the life of someone in extreme pain was considered a humane act. In modern times, however, this concept has become a matter of serious legal and ethical debate across the world, including India.

In India, the debate on euthanasia is shaped by three powerful forces: the law (especially Article 21 of the Constitution), the medical profession's ethics, and the deeply held religious and cultural beliefs of the people. While the courts have gradually permitted certain forms of euthanasia, comprehensive legislation on the subject is still absent. The Indian Parliament has not yet enacted any law specifically dealing with euthanasia, leaving the healthcare community to rely entirely on court-made guidelines.

This paper examines euthanasia from three angles: the constitutional and legal, the medical and ethical, and the global comparison. It aims to present a clear picture of where India stands today and the steps that need to be taken to build a fair and humane framework for end-of-life decisions.

2. TYPES OF EUTHANASIA

Before examining the law, it is essential to understand what types of euthanasia exist. Each type carries different legal and ethical implications.

I. Active Euthanasia

In active euthanasia, a doctor or medical professional takes a direct action to end the patient's life. For example, by administering a high dose of a lethal injection. The patient dies as a direct

result of this deliberate act. This form of euthanasia is illegal in India and is treated as a criminal offence under Sections 302 (murder) and 304 (culpable homicide not amounting to murder) of the Indian Penal Code, 1860.

II. Passive Euthanasia

In passive euthanasia, the medical treatment that is keeping a patient alive such as a ventilator, feeding tube, or other life-support equipment is withdrawn. The patient is allowed to die naturally without any active step being taken to cause death. The doctor does not cause death but simply ceases to prevent the natural process. This type of euthanasia has been recognised and conditionally permitted in India by the Supreme Court.

III. Voluntary and Involuntary Euthanasia

Voluntary euthanasia is when the patient themselves requests to be allowed to die, either directly or through a living will, also called an Advance Medical Directive. Involuntary euthanasia is when the decision is taken without the patient's consent, often because they are unconscious or in a coma. Involuntary euthanasia is generally prohibited worldwide and is considered equivalent to murder.

IV. Physician-Assisted Suicide

In physician-assisted suicide, the doctor does not directly cause death but provides the patient with the means, such as a prescription for lethal medication, which the patient then uses to end their own life. This is distinct from euthanasia, where the doctor directly administers the fatal substance. Physician-assisted suicide is legal in a few specific jurisdictions such as the state of Oregon in the United States.

3. ARTICLE 21 AND THE CONSTITUTIONAL FRAMEWORK

I. The Right to Life Under Article 21

Article 21 of the Indian Constitution states: 'No person shall be deprived of his life or personal liberty except according to the procedure established by law.' This provision is considered the most fundamental of all fundamental rights because it protects the life and personal freedom of every citizen.

Initially, Article 21 was interpreted narrowly; it simply meant that no one could be killed or imprisoned without a legal procedure. Over the years, however, the Supreme Court has greatly expanded its meaning. Today, Article 21 is understood to protect not merely the right to exist but the right to live a dignified, meaningful life. This includes the right to health, the right to a clean environment, the right to education, the right to privacy, and by judicial extension, the right to die with dignity.

II. Maneka Gandhi v. Union of India (1978) - Expanding Article 21

The 1978 judgement in Maneka Gandhi v. Union of India was a turning point in Indian constitutional law. The Supreme Court held that the procedure for depriving a person of life or liberty must be 'fair, just, and reasonable.' This introduced the concept of substantive due process into Indian jurisprudence. The court linked Article 21 with Article 14 (Right to Equality) and Article 19 (Right to Freedom), creating a web of interconnected fundamental rights. This expansive interpretation later provided the judicial tools to read the right to die with dignity as being inherent within Article 21.

III. Does Article 21 Include the Right to Die?

This is the central constitutional question in the euthanasia debate in India. In Gian Kaur v. State of Punjab (1996), the Supreme Court clearly held that the right to life under Article 21 does not include a right to die. The court reasoned that the right to life and the right to die are inherently contradictory in nature. However, the court importantly distinguished between the 'right to die' as such, which it did not recognise the 'right to die with dignity,' which it held could be treated as part of the right to a dignified life under Article 21.

This distinction between the unrecognised 'right to die' and the constitutionally protected 'right to die with dignity' became the foundation upon which all subsequent euthanasia jurisprudence in India was built.

4. KEY CASE LAWS ON EUTHANASIA IN INDIA

The development of euthanasia law in India has occurred almost entirely through judicial decisions. The following are the three most significant cases:

I. Gian Kaur v. State of Punjab (1996) — The Foundation

Case Summary: Gian Kaur v. State of Punjab, (1996) 2 SCC 648

In this case, the Supreme Court examined whether Sections 306 and 309 of the IPC, which punish abetment of suicide and attempt to commit suicide respectively, violated the right to life under Article 21. The court upheld these sections and clearly stated that Article 21 does not include any right to die. However, the court observed that a dignified life until natural death and therefore 'dying with dignity' could be treated as part of the right to life. This observation, though not a direct ruling on euthanasia, laid the legal groundwork for future judicial developments on end-of-life care.

II. Aruna Shanbaug v. Union of India (2011) — Passive Euthanasia Recognised

Case Summary: Aruna Ramchandra Shanbaug v. Union of India, (2011) 4 SCC 454

Aruna Shanbaug was a nurse at KEM Hospital, Mumbai, who was strangled and sexually assaulted in 1973. The attack left her in a Persistent Vegetative State (PVS) for 42 years, during which she remained entirely dependent on hospital staff with no consciousness or hope of recovery. In 2011, journalist Pinki Virani filed a petition seeking permission for euthanasia. The Supreme Court rejected active euthanasia but permitted passive euthanasia under strict judicially monitored conditions. Guidelines laid down: (1) The decision to withdraw life support must be taken bona fide in the patient's best interest; (2) High Court approval under Article 226 is mandatory; (3) A bench of at least two judges must be formed; (4) A medical committee of three doctors preferably a neurologist, psychiatrist, and physician must examine the patient and file a report; (5) Close relatives or next friend must be heard before any decision is made. These guidelines were to be followed across India until Parliament enacts legislation. The court ultimately found that Aruna herself did not qualify, as she could breathe independently and was not brain-dead.

III. Common Cause v. Union of India (2018) — Living Wills Legalised

Case Summary: Common Cause (A Regd. Society) v. Union of India, AIR 2018 SC 2002

A five-judge constitutional bench led by Chief Justice Dipak Misra delivered a unanimous verdict on 9th March 2018, holding that the right to die with dignity is a fundamental right under Article 21. The court recognised the concept of an 'Advance Medical Directive' (living will), allowing a person in sound mind to pre-record their wishes regarding medical treatment in the event of future incapacity or terminal illness. Key outcomes: (1) Passive euthanasia confirmed as a fundamental right; (2) Advance Medical Directives (living wills) legalised; (3) Directives must be signed before two witnesses and countersigned by a judicial magistrate; (4) A medical board must review the directive before life support is withdrawn. The judgement, spanning 538 pages, marked a philosophical shift in Indian law from a cautious case-by-case approach to a broader recognition of patient autonomy, dignity, and the right to refuse futile life-prolonging treatment.

IV. Comparison of the Two Landmark Cases

Country	Type Permitted	Key Conditions
Aruna Shanbaug (2011)	Specific to patients in PVS, required High Court approval for each case	Cautious and restrictive; minimal patient autonomy
Common Cause (2018)	Applies to any adult, a living will mechanism is available to all citizens	Patient autonomy central; simplified procedures established

5. LAW COMMISSION REPORTS ON EUTHANASIA

The Law Commission of India has played a significant advisory role in shaping euthanasia policy. Two key reports are particularly relevant.

I. 196th Report (2006) - Medical Treatment of Terminally ILL Patients

This report, titled 'Medical Treatment to Terminally ILL Patients (Protection of Patients and Medical Practitioners),' recommended that passive euthanasia be legally permitted under carefully regulated circumstances. It highlighted the right of a patient to die with dignity and proposed that decisions be made in consultation with medical experts and family members. This was among the first official acknowledgements that the existing legal framework was inadequate to deal with end-of-life care.

II. 241st Report (2012) - Passive Euthanasia: A Relook

Following the Aruna Shanbaug case, the Law Commission revisited the issue and reiterated that the absence of legislation was creating inconsistencies in the application of end-of-life care across different hospitals and states. The Commission recommended that Parliament enact a law to provide a formal structure for passive euthanasia, advance medical directives, and palliative care. Despite both reports, Parliament has not yet enacted a comprehensive law on this subject.

6. EUTHANASIA AND THE MEDICAL SECTOR

Euthanasia presents serious and complex questions for the medical profession. Doctors and healthcare providers are directly involved in end-of-life decisions, and the current legal ambiguity makes their position particularly difficult.

I. The Doctor's Oath and Medical Ethics

When doctors become registered medical practitioners, they take an oath to protect and save lives. The foundational principle of medical ethics is 'do no harm' (non-maleficence).

Euthanasia especially in its active form directly contradicts this principle and creates a deep moral conflict for healthcare professionals. In February 2008, the Medical Council of India's Ethics Committee stated clearly that 'practising euthanasia shall constitute unethical behaviour.'

However, it acknowledged that withdrawing life-sustaining equipment following brain death should be decided by a team of doctors rather than by the treating physician alone.

II. Challenges Faced by Healthcare Professionals

Doctors and nurses in India face the following major challenges in end-of-life situations:

- Moral Distress: When a patient is suffering severely with no hope of recovery, the inability to provide adequate relief without risking legal consequences causes significant moral distress to healthcare providers.

- Fear of Legal Action: Without comprehensive legislation, doctors who withdraw life support or decline to initiate treatment risk prosecution under the IPC. This fear causes many to continue futile treatment solely to protect themselves legally.

- Lack of Training in Palliative Care: Adequate training in palliative care and end-of-life counselling is largely absent from Indian medical education, leaving doctors unprepared for these emotionally and ethically complex situations.

- Communication Difficulties with Families: India's diversity of religious and cultural beliefs means that families often resist end-of-life decisions. Doctors frequently face resistance and are required to explain highly complex ethical issues without any formal framework guiding them.

- Role Confusion: In the absence of clear legal mandates, doctors are often uncertain about who should initiate end-of-life discussions, how to document such decisions, and what procedural steps to follow.

III. The Role of Palliative Care

Palliative care is a specialised area of medicine focused on providing relief from pain, stress, and other symptoms of serious illness. Many experts argue that expanding access to palliative care is among the most important steps India can take, as it can significantly reduce the incidence of euthanasia requests. Unfortunately, palliative care services in India remain very limited and are largely unavailable outside major urban center’s.

7. RELIGIOUS AND CULTURAL PERSPECTIVES

India is a country of enormous religious diversity, and religious beliefs strongly shape public attitudes towards euthanasia. Most major religions in India have reservations about the practice.

I. Hinduism

Hinduism presents a somewhat divided view. Many Hindus believe that a doctor should not comply with a patient's request for euthanasia because doing so separates the soul from the body at an unnatural time, thereby disrupting the cycle of karma and rebirth. The principle of Ahimsa (non-violence) is also invoked against euthanasia. Conversely, some Hindus hold that helping to end a painful life is a compassionate act fulfilling one's moral duty. Interestingly, keeping a person artificially alive indefinitely is itself seen by some as an unnatural interference in the natural cycle.

II. Islam

Islamic beliefs firmly oppose euthanasia. According to Islamic teaching, all human life is sacred because it is given by Allah, and human beings have no authority to decide when it should end. Life belongs to God, and terminating it except in the course of justice is strictly prohibited.

III. Christianity

Most Christian groups are opposed to euthanasia. Christian teaching holds that life is a gift from God, and human beings, being made in God's image, do not have the authority to terminate an innocent person's life even at that person's own request. Birth and death are processes only God may determine.

IV. Sikhism

The Sikh faith, drawing from the teachings of the Guru Granth Sahib and the Rehat Maryada, rejects euthanasia and suicide as interference in God's plan. Suffering is understood as part of the operation of karma, and Sikhs are encouraged to face it with faith and courage rather than seek an early end.

Despite these religious positions, it is important to note that in a secular democratic country such as India, the law must ultimately be guided by constitutional principles rather than

religious doctrine alone. The courts have consistently sought to balance religious sentiments with the constitutional rights of individuals.

8. EUTHANASIA IN OTHER COUNTRIES: A COMPARATIVE ANALYSIS

While India has only recognised passive euthanasia, several countries have gone considerably further by enacting comprehensive legislative frameworks. Understanding these models is critical for India's future policy direction.

Country	Type Permitted	Key Conditions
Netherlands	Active & Passive + Physician-Assisted Suicide	Voluntary request; unbearable suffering; no chance of improvement; second doctor's opinion required
Belgium	Active & Passive Euthanasia (including for minors under strict conditions)	Voluntary consent; physical or psychological suffering; psychiatric evaluation required
Canada	Medical Assistance in Dying (MAID) - active & passive	Grievous and irremediable medical condition; voluntary informed consent; adult patient
USA (Oregon)	Physician-Assisted Suicide only not active euthanasia	Terminally ill adult; 6-month prognosis; two verbal and one written request; mental competence assessed
India	Passive Euthanasia only and court-monitored	PVS or terminal illness; High Court approval; medical board review; valid living will or family consent

I. The Netherlands

The Netherlands was the first country in the world to legalise euthanasia through formal legislation, doing so in 2002 under the Termination of Life on Request and Assisted Suicide Act. Under Dutch law, euthanasia is permitted when the patient makes a voluntary, well-

considered, and persistent request; when the patient is experiencing unbearable suffering with no prospect of improvement; and when all other treatment options have been exhausted. A second independent doctor must be consulted and must concur with the decision. Importantly, the patient need not be terminally ill people suffering from chronic conditions, including in some cases psychiatric conditions, have been found eligible. Each case must be reported to a Regional Euthanasia Review Committee, which verifies compliance with the statutory requirements.

II. Belgium

Belgium enacted its euthanasia law in 2002. The Belgian law is considered more permissive than the Dutch model in certain respects. Belgium allows euthanasia not only for adults but also, under extremely strict conditions, for minors suffering unbearably from a terminal illness. The Belgian model explicitly recognises both physical and psychological suffering as valid grounds for requesting euthanasia. A Federal Control and Evaluation Commission reviews all reported cases. Belgium's experience demonstrates that a clearly defined legislative framework can promote transparency and reduce the risk of abuse.

III. Canada

Canada legalised Medical Assistance in Dying (MAID) in 2016 through an amendment to the Criminal Code. Canadian law requires that the person have a serious and incurable illness or disability and that they provide fully informed, voluntary consent without any external pressure. Canada's model is notable for having been expanded over time to cover non-terminal patients as well, provided their suffering is severe and not remediable by any means acceptable to them. Safeguards include a mandatory reflection period, multiple formal requests, and a requirement for independent witnesses.

IV. United States (State of Oregon)

In the United States, euthanasia is not legalised at the federal level, but several states beginning with Oregon, under the Death with Dignity Act of 1997, have legalised physician-assisted suicide. Under this model, a terminally ill patient with a prognosis of six months or less may request a prescription for life-ending medication from their physician, which the patient then self-administers. The physician provides the means but does not directly administer the

medication, a distinction that separates this from euthanasia. The Oregon model requires two verbal requests separated by a 15-day waiting period, one written request before two witnesses, and a mental health evaluation where necessary. Several other states including California, Colorado, Washington, and Hawaii have since enacted similar legislation.

V. What India Can Learn

India's approach, shaped entirely by judicial decisions rather than legislation, lacks the clarity and consistency of the international models described above. The key lessons India can draw are as follows:

- A clear and comprehensive statute provides certainty both for patients seeking a dignified death and for doctors implementing end-of-life decisions without fear of criminal prosecution.

- Robust safeguards such as mandatory medical board reviews, independent verification, and a cooling-off period can prevent abuse without making the process unnecessarily burdensome.

- Palliative care infrastructure must be developed alongside euthanasia policy to ensure that patients genuinely have alternative options for managing pain and suffering with dignity.

- Patient autonomy should be central to any legislative framework, with mechanisms such as advance medical directives made easily accessible to all citizens, including those in rural and semi-urban areas.

9. THE LIVING WILL AND ADVANCE MEDICAL DIRECTIVE

One of the most significant outcomes of the Common Cause judgement (2018) was the formal recognition of living wills termed Advance Medical Directives, in India. A living will is a legal document in which a person, while in good health and of sound mind, records their wishes about what medical treatment they want or do not want if they become unconscious or terminally ill at a future point.

For example, a person may state through a living will that they do not wish to be kept on a

ventilator indefinitely if there is no reasonable hope of recovery. This document empowers the patient to make their voice heard even when they are no longer in a position to communicate their wishes.

I. Requirements for a Valid Living Will in India

The Supreme Court in Common Cause laid down the following requirements for a valid Advance Medical Directive:

- The person must be an adult of sound mind at the time of making the directive.
- The directive must be signed in the presence of two adult witnesses.
- It must be countersigned by a judicial magistrate who is satisfied as to the voluntariness of the document.
- It must be preserved by the relevant hospital and by the judicial magistrate.
- A medical board must review the directive before any withdrawal of life support is carried out.

Shortly after the Common Cause judgement, an advocate in Kanpur became the first person in India to officially register a living will a significant symbolic milestone in the country's euthanasia jurisprudence.

10. ACTIVE VERSUS PASSIVE EUTHANASIA: WHY THE DISTINCTION MATTERS

The legal and ethical distinction between active and passive euthanasia is central to understanding India's current legal position. This distinction is not merely technical it reflects a deep philosophical question about the proper role of the state and of medical professionals in the process of dying.

I. Active Euthanasia

Active euthanasia involves a deliberate positive act, such as the administration of a lethal injection that directly causes the patient's death. Most legal systems treat this as too proximate

to killing, and the risks of abuse are considered substantial. In India, active euthanasia remains illegal and constitutes a criminal offence under the Indian Penal Code. It will remain so unless Parliament specifically enacts legislation to permit it.

II. Passive Euthanasia

Passive euthanasia involves withholding or withdrawing life-sustaining treatment. The legal and ethical argument is that in such cases, the underlying disease itself causes death the doctor is simply ceasing to stand in the way of nature. For this reason, courts and ethicists have been more willing to accept passive euthanasia, particularly where the patient has consented through a living will or is in an irreversible condition, such as PVS with no meaningful quality of life. The Supreme Court in Aruna Shanbaug (2011) drew this distinction clearly and permitted passive euthanasia while rejecting active euthanasia. The 2018 Common Cause judgment further consolidated this framework.

11. CHALLENGES AND THE WAY FORWARD

I. The Absence of Legislation

Despite two detailed Law Commission reports and three landmark Supreme Court decisions spanning over two decades, India still does not have a formal statute on euthanasia. The law exists only in judicial guidelines that are lengthy, procedurally complex, and not easily followed in practice by hospitals, patients, or families. The Medical Treatment of Terminally Ill Patients Bill, proposed in 2016, has not yet been enacted into law.

II. Lack of Public Awareness

A large section of India's population is not aware of concepts such as living wills or advance medical directives. Even in urban areas, survey data indicate that many citizens are unfamiliar with the legal provisions around passive euthanasia. In rural areas, awareness is even lower. This means most patients and families are unable to exercise their constitutional rights effectively.

III. Infrastructure Gaps in Palliative Care

India lacks sufficient palliative care facilities, particularly outside major metropolitan cities.

Without access to proper pain management and end-of-life support, families and patients are often left with no practical option but to either continue futile treatment or navigate the complex judicial process for passive euthanasia. Building palliative care infrastructure is an indispensable component of any comprehensive euthanasia policy.

IV. Risk of Misuse and Exploitation

A frequently raised concern about legalising Euthanasia, whether active or passive is the risk of misuse. Vulnerable individuals such as the elderly, the economically disadvantaged, or those suffering from mental illness may be subject to pressure from relatives motivated by inheritance or other selfish reasons. The Supreme Court in Aruna Shanbaug explicitly acknowledged this risk and made High Court approval mandatory as a safeguard. Any future legislation must incorporate strong protective mechanisms for vulnerable populations.

V. Recommendations

Based on the analysis in this paper, the following steps are recommended:

- Enact a comprehensive euthanasia and end-of-life care legislation that codifies the Supreme Court's guidelines and establishes a clear, accessible process for patients and their families.
- Simplify the process for executing and enforcing living wills, including digital registration, to make the mechanism genuinely accessible to all citizens regardless of their geographical location.
- Develop national guidelines and structured training programs for healthcare professionals to assist them in navigating end-of-life decisions with legal certainty and ethical confidence.
- Invest significantly in palliative care infrastructure across India, particularly in rural and semi-urban areas where the need is greatest.
- Launch sustained public awareness campaigns to educate citizens about their constitutional rights regarding end-of-life care, advance directives, and available palliative options.

- Establish independent oversight bodies within any legislative framework to ensure accountability, prevent misuse, and maintain public trust.

12. CONCLUSION

Euthanasia is one of the most difficult issues that a legal system and a society can be called upon to address, because it sits at the intersection of life, death, personal freedom, human dignity, and moral values. India has made considerable progress in this regard. From a position where the right to die was entirely unrecognised, the country has evolved to one where passive euthanasia is constitutionally protected and living wills carry legal validity.

The three landmark cases: Gian Kaur (1996), Aruna Shanbaug (2011), and Common Cause (2018) have collectively constructed a judicial framework that seeks to balance the right of individuals to die with dignity against the necessity of safeguards to prevent abuse. The Law Commission's reports have added important legislative recommendations. Medical ethics continues to evolve, and there is growing recognition within the healthcare profession that patient autonomy must be meaningfully respected.

However, India remains significantly behind countries such as the Netherlands, Belgium, and Canada, which have enacted comprehensive legislative frameworks regulating euthanasia. The absence of a formal statute in India means legal uncertainty persists, healthcare professionals remain exposed to risk, and vulnerable patients may not receive adequate protection.

The time has come for the Indian Parliament to step in and do what the courts have repeatedly and urgently called for: enact a clear, humane, and carefully safeguarded law on euthanasia and end-of-life care. Such a law must place the patient's dignity at its centre, protect vulnerable individuals from exploitation, support medical professionals with unambiguous guidelines, and ensure that every citizen of India has the right to a death that is as peaceful and dignified as the life they lived.

REFERENCES

A. Case Laws

Gian Kaur v. State of Punjab, (1996) 2 SCC 648.

Aruna Ramchandra Shanbaug v. Union of India, (2011) 4 SCC 454.

Common Cause (A Regd. Society) v. Union of India, AIR 2018 SC 2002.

Maneka Gandhi v. Union of India, AIR 1978 SC 597.

Francis Coralie Mullin v. The Administrator, Union Territory of Delhi, AIR 1981 SC 746.

B. Statutes and Constitutional Provisions

Constitution of India, 1950 — Article 21 (Right to Life and Personal Liberty).

Indian Penal Code, 1860 — Sections 302, 304, 306 and 309.

Mental Healthcare Act, 2017 — Section 115.

Transplantation of Human Organs Act, 1994.

Bharatiya Nyaya Sanhita — Provisions relating to suicide and abetment.

C. Law Commission Reports

Law Commission of India, 196th Report — Medical Treatment to Terminally Ill Patients (Protection of Patients and Medical Practitioners) (2006).

Law Commission of India, 241st Report — Passive Euthanasia: A Relook (2012).

D. Research Papers and Articles

Srivastava, A. & Laxmi, V., 'An Analysis of Euthanasia & Right to Die Laws in India,' Indian Journal of Integrated Research in Law, Volume V, Issue II.

Sujata, P. & Choudhury, S., 'Dying with Dignity: A Legal and Ethical Analysis of Euthanasia

in an Indian Perspective,' IJETIR, Volume 5, Issue 3 (March 2025).

Singh, J. & Shrivastava, A., 'Euthanasia and Indian Constitution: A Comparative Legal Analysis,' Indian Journal of Law and Legal Research, Volume VII, Issue II.

Cyriac, B.T., 'Euthanasia and Its Societal Implications: A Research Paper,' Indian Journal of Legal Review (IJLR), Volume 4, Issue 1 (2024).

Debnath, B. et al., 'A Study on Exploring the Legality of Euthanasia in India: An Ethical Dilemma of the Medicine Industry,' IJIRT, Volume 10, Issue 11 (April 2024).