EUTHANASIA IN INDIA: THE RIGHT TO DIE WITH DIGNITY AND THE NEED FOR A STATUTORY FRAMEWORK

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ABSTRACT

Euthanasia lies at the difficult confluence of constitutional liberty, medical ethics, criminal law and the State's competing interest in preserving life. The Supreme Court's decisions in P. Rathinam v. Union of India, Gian Kaur v. State of Punjab, Aruna Ramachandra Shanbaug v. Union of India and Common Cause v. Union of India have shaped Euthanasia in India. Recently, the Supreme Court's 2026 decision in Harish Rana v. Union of India further clarified the operation of passive euthanasia, particularly in relation to clinically assisted nutrition and hydration in cases of irreversible vegetative states. This article discusses the judicial recognition of the right to die with dignity and the practice of active and passive euthanasia in several other countries and argues that the need for a clear statutory framework within India. Judicial recognition will not, on its own, create a stable, easily accessible framework for making end-of-life decisions. Therefore, this article argues that Parliament should enact a regulatory framework based on autonomy and dignity that includes medical safeguards, transparency and protection for vulnerable persons.

Keywords: Euthanasia; Passive Euthanasia; Right to Die with Dignity; Article 21; Living Will; Advance Medical Directive; End-of-Life Care; Medical Ethics; Constitutional Law.

1. Introduction

There lies a crucial question in euthanasia: where modern medicine allows biological functions to be maintained for long periods when recovery is impossible, the question is whether the law should require medical interventions to be continued when such treatments no longer offer any realistic chance of recovery and are against the patient's wishes or dignity. Modern medicine can sustain biological functions for prolonged periods even when recovery is medically impossible.

The word 'euthanasia' derives from the Greek terms eu, meaning 'good', and thanatos, meaning 'death'. The expression includes different ways to end life: active euthanasia, passive euthanasia, voluntary euthanasia and physician-assisted dying. [1]

Active euthanasia involves a positive act intended to cause death, whereas passive euthanasia refers to withholding or withdrawing medical treatment or life-sustaining treatment in certain circumstances in which the law permits it. Physician-assisted dying is where the physician provides means by which the patient may end his or her own life. This becomes relevant in the Indian context because, while the Supreme Court has accepted passive euthanasia under the constitutional guarantee of dignity, it has categorically rejected active euthanasia.

The Indian discussion has moved forward after Aruna Ramachandra Shanbaug v. Union of India (2011), wherein the Supreme Court allowed passive euthanasia under proper safeguards. Later, the Constitution Bench judgment in Common Cause v. Union of India (2018) placed the right to die with dignity within Article 21 and recognized advance medical directives (living will). The judgment in Harish Rana v. Union of India (2026) fleshed out this scheme in its application to the withdrawal and withholding of medical treatment, including clinically assisted nutrition and hydration, in the facts of that case.

2. Euthanasia and Indian Constitutional Jurisprudence

Article 21 of the Constitution protects life and personal liberty but has been evolved by the Supreme Court to include rights which make life in consonance with human dignity. But the question of euthanasia involves a conflict; on the one hand, the State has a legitimate interest in protecting life, but on the other hand, the individual has competing interests in autonomy, bodily integrity, privacy and dignity. [2] [3]

2.1 P. Rathinam v. Union of India

In P. Rathinam v. Union of India, (1994) 3 SCC 394, the Supreme Court considered whether the right to life under Article 21 included a right to die and held, at that stage of the jurisprudence, that it did. It further struck down Section 309 of the Indian Penal Code on the ground that it was inconsistent with the rights under Article 21. This judgment was later overruled in Gian Kaur. [4]

2.2 Gian Kaur v. State of Punjab

In Gian Kaur v. State of Punjab, (1996) 2 SCC 648, a five-judge Constitution Bench rejected the proposition that Article 21 contains a general right to die. The Court held that the right to life does not extend to the right to die. At the same time, the judgment recognised that the right to live with dignity would include the dignity of the process of dying. This formed the basis for the later development of passive euthanasia jurisprudence. [5]

2.3 Aruna Ramachandra Shanbaug v. Union of India

The decision in Aruna Ramachandra Shanbaug v. Union of India, (2011) 4 SCC 454, marked a major development in recognition of Euthanasia in Indian jurisprudence. The Supreme Court accepted that passive euthanasia could, in carefully controlled circumstances, be legally permissible. It distinguished the withdrawal of life-sustaining treatment from an intentional positive act designed to cause death and introduced procedural safeguards to prevent arbitrary decisions. [6] This was a significant moment that shifted the question from whether there was a generalized right to die to a constitutional question about whether medical intervention should be continued in the case of patients who were either in a permanent vegetative state or suffering from an irreversible condition.

2.4 Common Cause v. Union of India

The Constitution Bench decision in Common Cause (A Regd. Society) v. Union of India, brought substantial clarity in the constitutional position. The Court held that the right to die with dignity forms part of the right to life under Article 21. It also recognised the validity of advance medical directives, commonly known as living wills, subject to safeguards and procedural requirements. [7]

It is obvious from the judgment that the Court was not supportive of maintaining artificial

medical intervention to prolong the life of a person who had little to no chance of survival and supported euthanasia to preserve human dignity. At the same time, the Court did not constitutionalise active euthanasia as this could lead to misuse. This implies a legal position wherein, on the one hand, treatment may be withdrawn or withheld to let the dying process take place naturally, and on the other hand, active euthanasia, which is a positive act to cause death, remained prohibited.

2.5 Harish Rana v. Union of India (2026)

The Supreme Court's judgment in Harish Rana v. Union of India, represents an important subsequent development. The case concerned a patient in an irreversible vegetative state and the withdrawal or withholding of medical treatment, including clinically assisted nutrition and hydration (CANH). The Court treated CANH within the framework of medical treatment capable of being withdrawn in appropriate circumstances and directed that the treatment be withdrawn or withheld in the facts of the case. [8]

The Harish Rana case demonstrates the operation of the principles articulated in Common Cause and clarifies that passive euthanasia is not confined to the withdrawal of a ventilator or other conventional life-support equipment. The decision also highlights the continuing absence of comprehensive parliamentary legislation governing end-of-life decisions in India and the importance of clear procedural safeguards for the practice of euthanasia.

2.6 Chandrakant Narayanrao Tandale v. State of Maharashtra

In Chandrakant Narayanrao Tandale v. State of Maharashtra, the Bombay High Court considered a request for active euthanasia and reaffirmed the distinction between active and passive euthanasia. The court held that constitutional recognition of a right to die with dignity does not include a right to demand an intentional medical act whose purpose is to cause death. The case therefore reinforces the continuing legal boundary between permissible withdrawal or withholding of treatment and active euthanasia. [9]

2.7 Santhara and the Question of Voluntary Death

The constitutional debate has also arisen in the context of Santhara (Sallekhana), a Jain religious practice involving voluntary fasting unto death. In Nikhil Soni v. Union of India, the Rajasthan High Court held that it is not an essential religious practice under Section 25 of the Indian Constitution. Hence, it is treated as an illegal practice, falling within suicide under penal

law. [10]

3. Legislative Reform and the Need for a Statutory Framework

Indian euthanasia jurisprudence has developed primarily through judicial decisions rather than a comprehensive parliamentary statute. The Law Commission of India's 241st Report, 'Passive Euthanasia – A Relook', examined the subject and proposed a draft bill concerning medical treatment of terminally ill patients, which also sought to regulate the withdrawal of life-sustaining treatment and provide protection to medical practitioners acting in accordance with prescribed procedures. [11] [12]

The absence of comprehensive legislation creates uncertainty for patients, families, physicians and hospitals. Judicial guidelines are indispensable where legislation is absent, but they cannot entirely substitute for a detailed statutory scheme capable of addressing changing medical technology, institutional responsibilities, documentation, review mechanisms and accountability.

4. Euthanasia: Comparative Legal Position

The legal regulation of euthanasia differs considerably from country to country. Some countries permit voluntary active euthanasia under strict statutory conditions, while others permit only forms of assisted dying or withdrawal of medical treatment that is passive euthanasia. The different models demonstrate the range of safeguards that may be considered when constructing a domestic framework by comparative analysis.

4.1 The Netherlands

The Netherlands provides an advanced statutory framework. The Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001 entered into force in 2002. The framework liberally allows active euthanasia and physician-assisted suicide where statutory due-care requirements are satisfied. These requirements include a voluntary and well-considered request, unbearable suffering without prospect of improvement, adequate information concerning the patient's condition, consultation with an independent physician, and medically appropriate performance of the procedure. [13]

The Dutch model also incorporates post-procedure review, mandating that physicians report relevant cases, which are assessed by regional review committees. This institutionalized

mechanism balances individual autonomy with transparency, professional accountability and protection against abuse.

4.2 Belgium

Belgium decriminalised voluntary euthanasia through its 2002 legislation. The framework requires a voluntary and considered request, a serious and incurable medical condition, and persistent and unbearable physical or psychological suffering that cannot be alleviated. The Belgian framework also addresses requests by minors under specified safeguards. [14]

4.3 Luxembourg

Luxembourg legalised euthanasia and physician-assisted suicide through legislation enacted in 2009. The legal framework requires, among other conditions, legal capacity, a voluntary and repeated request free from external pressure, an incurable medical condition and persistent suffering. The legislation also requires medical consultation and reporting to a national control and evaluation body, thereby combining autonomy with institutional oversight. [15]

4.4 Canada

Canada has a statutory framework that developed following Carter v. Canada (Attorney General), [2015] 1 SCR 331, and subsequent legislation for medical assistance in dying. The Canadian system has detailed eligibility requirements, procedural safeguards, and review mechanisms, especially in cases of assisted dying. [16]

4.5 United States

The United States does not have a uniform model permitting active euthanasia. However, patients generally possess legal rights to refuse medical treatment, and several states permit medical aid in dying under statutory conditions. The American experience demonstrates the significance of distinguishing the right to refuse treatment from a right to receive an intentional life-ending intervention. [17]

4.6 United Kingdom

Active euthanasia and assisting suicide are unlawful in the United Kingdom. But English law allows a competent person to refuse specified medical treatment in the future. The UK position

therefore recognises patient autonomy in refusing treatment without legalising active euthanasia. [18]

4.7 Australia

Voluntary assisted dying legislation is permitted in all six Australian states. The statute imposes eligibility requirements and procedural safeguards, relating to advanced and incurable illness, decision-making capacity and medical assessment. [19]

4.8 France

France has not legalized voluntary euthanasia but permits forms of end-of-life care, including continuous deep sedation in certain circumstances. [20]

5. Euthanasia and Its Position in India

In the present Indian scenario, Active euthanasia is not recognised as a constitutional right. Passive euthanasia, by contrast, is permissible within the constitutional framework of the right to die with dignity, subject to the safeguards developed by the Supreme Court. Advance medical directives provide a mechanism through which a competent individual may express preferences concerning future medical treatment.

The legal position is therefore better described as a regulated right to refuse or withdraw life-sustaining treatment on a case-by-case basis rather than as a general right to demand euthanasia.

6. Need for Passive Euthanasia and a Clear Legislative Framework

A statutory framework for euthanasia must be grounded in constitutional values and accompanied by safeguards capable of protecting patients who may be vulnerable because of age, disability, illness, dependence or family pressure.

6.1 Relief from Futile and Disproportionate Treatment

Where medical treatment offers no realistic prospect of recovery and merely prolongs the biological process of dying, compulsory continuation may conflict with the patient's dignity and previously expressed wishes. A carefully regulated framework can permit treatment to be withheld or withdrawn while ensuring continued palliative and comfort care.

6.2 Predictability and Protection for Patients and Medical Professionals

Clear legislation can establish uniform standards for doctors, hospitals, medical boards and families. It can define eligibility, specify documentation requirements, establish independent review and provide protection to patients from misuse and to professionals who act in good faith and in accordance with the law.

6.3 Reducing Procedural Delay

End-of-life decisions are time-sensitive. Procedural delay can impose considerable emotional and financial burdens on families by prolonging treatment that the patient would not have wanted. A statutory mechanism should therefore preserve judicial oversight where necessary but provide an efficient medical and administrative process for routine cases.

6.4 Separation of Powers and Democratic Legitimacy

The judiciary has adjudicated on individual cases of euthanasia in the absence of legislation. But euthanasia involves complex policy questions beyond adjudication. The Parliament is institutionally better placed to conduct consultation with medical professionals, disability-rights groups, and civil society before establishing a comprehensive statutory framework.

6.5 Healthcare Costs and Family Burden

Long-term intensive care can impose substantial financial and emotional burdens on families. Cost, however, should not become an independent justification for ending a person's life. Any statutory framework must ensure that euthanasia or withdrawal of treatment is not chosen because adequate palliative care, insurance coverage or social support is unavailable.

6.6 Autonomy, Privacy and Dignity

Personal autonomy is of paramount importance in end-of-life decision-making. A competent person must be well within his rights to determine which medical interventions may be administered to the body. This principle is closely connected with dignity and privacy under Article 21.

6.7 Record-Keeping and Transparency

A regulated system can generate reliable information concerning end-of-life decisions.

Mandatory reporting, centralised records and periodic publication of anonymised statistics would improve transparency and allow policymakers to assess whether safeguards are effective. Such records would also make it easier to identify abuse, mala fides application or regional disparities.

6.8 Legal Protection and Accountability

A statutory framework can provide protections for doctors, patients and families and establish liability where the prescribed safeguards are violated. This would reduce uncertainty and create accountability for arbitrary continuation of treatment and unlawful termination of life.

6.9 Organ Donation

Organ donation should never determine whether treatment is withdrawn or death is permitted. The decision concerning withdrawal of treatment must be made independently of any potential benefit to organ recipients.

7. Data and Statistics: The Need for Reliable Indian Evidence

There is an inherent lack of national-level data on passive euthanasia and withdrawal or withholding of life-sustaining treatment. Without such data, it is impossible to know how often these decisions are made, how hospitals apply judicial safeguards as enumerated in cases, the kinds of difficulties families face, or whether any vulnerable groups are disproportionately affected.

By comparison with various countries, it is observed that permitting assisted dying or euthanasia requires reporting and review. India could similarly require reporting, periodic review and publication of data to promote transparency without compromising patient confidentiality.

8. Proposed Framework for Euthanasia Legislation in India

Future Indian legislation should preserve the distinction between active euthanasia and lawful withdrawal or withholding of medical treatment. The statute should incorporate, at minimum, the following safeguards:

• A precise statutory definition of active euthanasia, passive euthanasia, withholding treatment,

withdrawal of treatment, palliative care and advance medical directives.

• Recognition of the competent adult patient's right to refuse medical treatment, subject to clearly defined procedural requirements.

• A formal mechanism for creating, registering and verifying advance medical directives, with safeguards against coercion, fraud and undue influence.

• Independent medical assessment, including confirmation of diagnosis, prognosis, and the medical appropriateness of withdrawing or withholding treatment.

• A structured process for patients incapable of decision-making, having no applicable advance directive, with decisions based on the patient's best interests and previously expressed wishes.

• Mandatory documentation, reporting and review of cases in which life-sustaining treatment is withdrawn or withheld under the statutory framework.

• Accessible judicial review for disputed or exceptional cases, while avoiding unnecessary procedural delays in medically urgent situations.

• Legal protection for medical professionals who act in good faith and comply with the statutory requirements, and penalties for coercion, fraud, abuse or non-compliance.

9. Conclusion

The Indian euthanasia debate has moved considerably beyond the earlier proposition that the law must preserve life at all costs. The constitutional recognition of dignity, autonomy, privacy and bodily integrity has compelled the legal system to allow death when medical technology can sometimes prolong biological existence against the will of the patient.

The Supreme Court's jurisprudence, beginning with the conflicting approaches in P. Rathinam and Gian Kaur and developing through Aruna Shanbaug and Common Cause, has established a constitutional basis for the right to die with dignity. Harish Rana has provided a significant application of the doctrine by permitting withdrawal or withholding of medical treatment, including CANH, in the circumstances of an irreversible vegetative state.

However, judicial recognition cannot by itself provide a complete legal architecture for end-

of-life care. India requires legislation that is precise, humane and protective of vulnerable persons. Such legislation should not transform economic hardship or family burden into a justification for ending life. Instead, it should ensure that decisions are based on informed choice, dignity, medical evidence, and the patient's best interests.

Ultimately, the objective of end-of-life law should not be to choose between life and death in the abstract. Its purpose should be to ensure that when death is inevitable, and medical treatment can no longer provide meaningful benefit, the law permits a person to approach the end of life with dignity, compassion and appropriate legal protection. A designed statutory framework would make this principle more consistent and transparent across India.

Endnotes:

[1] National Library of Medicine, "Euthanasia and assisted suicide: An in-depth review of relevant historical aspects" (2022).

[2] Constitution of India, art. 21.

[3] Universal Declaration of Human Rights, art. 3 (1948).

[4] P. Rathinam v. Union of India, (1994) 3 SCC 394; AIR 1994 SC 1844.

[5] Gian Kaur v. State of Punjab, (1996) 2 SCC 648; AIR 1996 SC 946.

[6] Aruna Ramachandra Shanbaug v. Union of India, (2011) 4 SCC 454.

[7] Common Cause (A Regd. Society) v. Union of India, (2018) 5 SCC 1; AIR 2018 SC 1665.

[8] Harish Rana v. Union of India, 2026 INSC 222 (Supreme Court of India, 11 March 2026).

[9] Chandrakant Narayanrao Tandale v. State of Maharashtra, Bombay High Court, AIRONLINE 2020 BOM 2491.

[10] Nikhil Soni v. Union of India, MANU/RH/1345/2015 (Rajasthan High Court).

[11] Law Commission of India, Report No. 241, Passive Euthanasia – A Relook (Aug. 2012).

[12] Ministry of Health and Family Welfare, Government of India, Lok Sabha Unstarred Question No. 2231, answered 6 May 2016 (discussing the Law Commission's proposed legislation on passive euthanasia).

[13] Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001 (Netherlands), effective 1 April 2002.

[14] Belgian Act on Euthanasia, 28 May 2002, as amended.

[15] Law of 16 March 2009 on euthanasia and assisted suicide (Luxembourg).

[16] Carter v. Canada (Attorney General), [2015] 1 SCR 331; Medical Assistance in Dying

provisions under Canada's Criminal Code.

[17] See generally Cruzan v. Director, Missouri Department of Health, 497 U.S. 261 (1990) (recognising a competent person's liberty interest in refusing unwanted medical treatment).

[18] Suicide Act 1961 (UK), § 2; Mental Capacity Act 2005 (UK), including provisions concerning advance decisions to refuse treatment.

[19] Voluntary Assisted Dying Act 2017 (Vic.); Voluntary Assisted Dying Act 2019 (WA); End-of-Life Choices (Voluntary Assisted Dying) Act 2021 (Tas.); Voluntary Assisted Dying Act 2021 (Qld.); Voluntary Assisted Dying Act 2021 (SA); Voluntary Assisted Dying Act 2022 (NSW).

[20] Code de la santé publique (France), provisions concerning patients' rights, unreasonable obstinacy and continuous deep sedation; Law No. 2016-87 of 2 February 2016 creating new rights for patients and persons at the end of life.