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ADJUDICATING PSYCHIATRIC EUTHANASIA: A NEURO-LEGAL FRAMEWORK FOR JUDICIAL AUTHORISATION OF ASSISTED DYING

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ABSTRACT

When a patient's body succumbs to cancer, courts can read the scan, weigh the prognosis, and anchor their judgment in objective pathology. When the *mind* itself is the site of suffering when treatment-resistant psychiatric illness strips a person not of breath but of the will to inhabit their own life courts are asked to authorise an irreversible act on evidence that is phenomenological, diagnostically unstable, and legally uncharted. This is the foundational crisis of psychiatric euthanasia.

Existing euthanasia frameworks, particularly the due-care regimes of the Netherlands and Belgium, were architectured around somatic pathology. Their extension to psychiatric disorders has exposed a structural void: indeterminate irremediability standards, capacity assessments that fluctuate with the very illness being evaluated, and judicial deference to clinical discretion that would be constitutionally impermissible in any other capital-consequence adjudication. India carrying 14,305 mental illness–linked suicides annually [1] and permitting only passive euthanasia [2] confronts this void without any framework at all.

This paper proposes a judicially operable neuro-legal framework requiring (I) neurobiological substantiation, (II) longitudinal decisional capacity assessment, (III) disorder-specific eligibility criteria, and (IV) proportionality review**,** equipping courts to distinguish legally cognisable medical suffering from non-justiciable existential distress, while safeguarding autonomy, dignity, and the rule of law. The framework is grounded in comparative analysis of the Netherlands, Belgium, and Canada; doctrinal examination of landmark decisions under ECHR jurisprudence and Indian constitutional law; synthesis of a systematic review of 50 peer-reviewed studies; [3] and normative legal analysis calibrated to India's constitutional and infrastructural context.

Keywords: Psychiatric euthanasia, neuro-legal framework, judicial authorisation, decisional capacity, irremediability, due-care criteria, Article 21, parens patriae, Mental Healthcare Act 2017. proportionality review

[1]National Crime Records Bureau, Ministry of Home Affairs, Accidental Deaths & Suicides in India 2024 (Gov't of India 2024) [hereinafter NCRB 2024].

[2]Common Cause v. Union of India, (2018) 5 SCC 1 (India).

[3]Literature search conducted using Consensus AI-assisted research platform incorporating Semantic Scholar and PubMed; total corpus: 87,991,504 papers; screened: 228; eligible: 164; included: 50.

INTRODUCTION

When the right to life is no longer dignified, courts across the world are slowly being compelled to answer whether the law can and should permit a dignified death. A patient bedridden by stage-four cancer wears their suffering visibly: the tumour has a name, a staging, a scan, a prognosis. But what of the patient whose treatment-resistant depression has survived every pharmaceutical intervention, every hospitalisation, every attempt at recovery across decades and whose psychiatrist has concluded that no reasonable prospect of improvement exists? [4] Their pain does not show on an MRI. Their irremediability cannot be confirmed by biopsy. To insist that their suffering is legally invisible simply because it is neurologically complex is not caution it is discrimination dressed as procedural rigour.

This is the foundational paradox: the law demands objectivity from a domain that medicine itself has not yet fully objectified. The *Termination of Life on Request and Assisted Suicide (Review Procedures) Act, 2002* of the Netherlands and the Belgian *Euthanasia Act, 2002* the two most consequential legislative instruments in this field were architectured around somatic suffering. [5] Belgium recorded 370 psychiatric-only euthanasia cases over 2002–2021, constituting approximately 1.4% of all reported euthanasia. [6] The Netherlands has seen a parallel trend, with psychiatric cases characterised uniformly by long illness duration, multiple failed treatment attempts, and significant histories of prior suicide attempts. [7] What both jurisdictions reveal is not a robust legal architecture purpose-built for psychiatric claims but a somatic framework pressed into service for a category of suffering it was never designed to bear.

The legal difficulty is not merely moral but deeply epistemic. Courts are institutions built to evaluate external, verifiable, adversarially contestable evidence. Psychiatric euthanasia claims, by contrast, are grounded in phenomenological suffering. [8] The DSM-5 and ICD-11 diagnostic criteria are products of clinical consensus rather than neurobiological confirmation there are, as of today, no universally validated biomarkers for major depressive disorder, treatment-resistant depression, borderline personality disorder, or schizophrenia. [9] When a court in a somatic case evaluates irremediability, it reads an oncologist's documented clinical trajectory. When a court in a psychiatric case does the same, it evaluates a contested expert opinion about the ceiling of psychiatric treatment a ceiling that over 150 conflicting clinical definitions of 'treatment-resistant depression' alone have made extraordinarily difficult to locate. [10]

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[4]Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding [Termination of Life on Request and Assisted Suicide (Review Procedures) Act] (Neth. 2002); Wet betreffende de euthanasie [Belgian Euthanasia Act] (Belg. 2002).

[5]Marc De Hert & Kris Van Assche, Euthanasia for Unbearable Suffering Caused by a Psychiatric Disorder: Improving the Regulatory Framework, 23 World Psychiatry (2024), https://doi.org/10.1002/wps.21152.

[6]Id.

[7]Raluca Calati et al., Euthanasia and Assisted Suicide in Psychiatric Patients: A Systematic Review of the Literature, 135 J. Psychiatric Res. 153 (2020); Scott Y.H. Kim et al., Euthanasia and Assisted Suicide of Patients with Psychiatric Disorders in the Netherlands 2011 to 2014, 73(4) JAMA Psychiatry 362 (2016).

[8]Matteo Scopetti et al., Assisted Suicide and Euthanasia in Mental Disorders: Ethical Positions in the Debate Between Proportionality, Dignity, and the Right to Die, 11 Healthcare (2023), https://doi.org/10.3390/healthcare11101470.

[9]Lorenzo Grassi et al., Debating Euthanasia and Physician-Assisted Death in People with Psychiatric Disorders, 24 Current Psychiatry Rep. 325 (2022).

[10]Kim et al., supra note 7 (noting clinical difficulty in establishing irremediability given over 150 conflicting definitions of treatment-resistant depression).

India enters this debate from a position of particular constitutional and infrastructural complexity. The Supreme Court, in *Common Cause v. Union of India*[11], constitutionally entrenched the right to die with dignity as a dimension of Article 21 but confined its authorisation to passive euthanasia alone in cases of terminal illness or persistent vegetative state. Active euthanasia and physician-assisted suicide remain categorically prohibited. No judicial or legislative framework exists for psychiatric euthanasia whatsoever not even a preliminary procedural scaffold. This is a country where, according to the National Crime Records Bureau, 14,305 suicides in 2024 were attributable to mental illness alone one death every thirty-six minutes where the 18–45 age group accounted for sixty percent of that burden, and where even children were not spared, with 844 documented deaths. [12] Karnataka alone recorded 2,465 such deaths. [13] These are not abstract statistics. They represent a population experiencing unbearable psychiatric suffering at a scale that makes the question of whether Indian courts have any legal tools to address end-of-life dignity not merely academic but urgent.

The comparative landscape offers important but imperfect guidance. Canada's Supreme Court, in *Carter v. Canada (Attorney General)*[14], struck down the blanket prohibition on assisted dying, but subsequent legislative attempts to include psychiatric disorders under Medical Assistance in Dying have been repeatedly deferred most recently until at least March 2027 [15] precisely because the legislature recognises that psychiatric euthanasia raises qualitatively distinct evidentiary questions that somatic frameworks cannot resolve. The European Court of Human Rights, in *Pretty v. United Kingdom*[16], held that Article 2 cannot confer a right to die, while in *Haas v. Switzerland*[17] it acknowledged that Article 8 encompasses decisions about how and when to die. In *Mortier v. Belgium*[18], the Court found that Belgian psychiatric euthanasia did not per se violate the Convention but required procedural safeguards sufficiently robust to discharge positive obligations under Article 2. The Dutch Supreme Court's 2020 ruling in *ECLI:NL:HR:2020:712*[19] the 'coffee euthanasia' case sanctioned euthanasia in the absence of contemporaneous consent relying on a prior advance directive, with constitutional implications that, if transposed uncritically to psychiatry, are alarming.

India's civilisational heritage adds a dimension that Western euthanasia law has barely acknowledged. Jainism's doctrine of *Sallekhana* voluntary fasting unto death has been protected as a religious practice by Indian courts, [20] and Hinduism's *Prayopavesa* reflects a theological tradition that regards consciously chosen death as liberation when the body can no

[11]Common Cause v. Union of India, (2018) 5 SCC 1 (India).

[12]NCRB 2024, supra note 1, at tbl. A-1.7 (recording 14,305 suicides attributable to mental illness; 18–45 age group: 60%; minors under 18: 844 deaths). Karnataka figure: id. at state-wise table.

[13]Id.

[14]Carter v. Canada (Attorney General), [2015] 1 SCR 331 (Can.).

[15]Sanjay Bahji & Nicholas Delva, Making a Case for the Inclusion of Refractory and Severe Mental Illness as a Sole Criterion for Canadians Requesting Medical Assistance in Dying (MAiD): A Review, 48 J. Med. Ethics 929 (2021).

[16]Pretty v. United Kingdom, App. No. 2346/02, 35 Eur. H.R. Rep. 1 (2002).

[17]Haas v. Switzerland, App. No. 31322/07, Eur. Ct. H.R. (2011).

[18]Mortier v. Belgium, App. No. 78017/17, Eur. Ct. H.R. (2022).

[19]Hoge Raad [HR] [Supreme Court of the Netherlands], Apr. 21, 2020, ECLI:NL:HR:2020:712 (Neth.) [hereinafter Coffee Euthanasia Case].

[20]Naresh Kadyan v. Union of India, Writ Petition No. 855 of 2015 (Rajasthan H.C., India) (stayed by Supreme Court of India, Aug. 31, 2015); Pavan Navandar, Euthanasia in India: A Legal, Socio-Cultural, and Psychological Analysis of the Right to Die with Dignity, Int'l J. for Res. in Applied Sci. & Eng'g Tech. (2026), https://doi.org/10.22214/ijraset.2026.79138.

longer sustain meaningful human existence. [21] These traditions demonstrate that within India's own jurisprudential heritage, the binary between 'protecting life' and 'permitting chosen death' was never absolute and that the conditions under which death may be chosen (voluntariness, exhaustion of alternatives, community oversight) are remarkably resonant with the legal criteria a neuro-legal framework must establish.

The paper is organised as follows. Part II surveys comparative frameworks governing psychiatric euthanasia in the Netherlands, Belgium, and Canada, identifying structural deficiencies from applying somatic evidentiary logic to psychiatric claims. Part III analyses Indian statutory and doctrinal loopholes. Part IV synthesises the neuroscientific literature on psychiatric irremediability, neurodegeneration, and decisional capacity. Part V proposes the four pillars of the neuro-legal framework: neurobiological substantiation, longitudinal decisional capacity assessment, disorder-specific eligibility criteria, and proportionality review with specific application to India's constitutional and infrastructural context. Part VI concludes with limitations and open research questions for future legislative reform.

RESEARCH METHODOLOGY AND OBJECTIVES

This article adopts a doctrinal and normative legal methodology, supplemented by interdisciplinary analysis drawn from neuroscience, clinical psychiatry, and comparative public law. [22] It is not an empirical study. It does not advance statistical claims about the prevalence of psychiatric euthanasia requests, nor does it take a position on whether psychiatric euthanasia is desirable as social policy. What it does deliberately, precisely, and exclusively is examine how courts should reason when confronted with psychiatric euthanasia claims in the absence of any existing judicial standard calibrated to the unique evidentiary character of psychiatric suffering.

Existing legal scholarship on euthanasia has, almost without exception, addressed the question from either a bioethical or a legislative standpoint asking whether assisted dying should be permitted, and under what statutory conditions. Conspicuously absent is a framework addressed to the court itself: to the judge who must evaluate expert psychiatric testimony, weigh contested irremediability assessments, determine the validity of consent in a fluctuating mental state, and ultimately authorise or refuse an irreversible act. [23] In India, this gap has no legislative supplement because no such legislation exists.

B. The Four-Pronged Methodological Framework

First Comparative Legal Analysis. The paper undertakes a systematic comparative examination of euthanasia regimes in the Netherlands, Belgium, and Canada with supplementary reference to Spain and Switzerland to expose structural weaknesses in frameworks that evolved by extending somatic evidentiary logic to psychiatric claims without redesigning the underlying legal architecture. [24] The comparison is conducted through primary statutory texts, secondary doctrinal commentary, and review committee reports.

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[21]Fernand Paul et al., Euthanasia in Psychiatric Practice: Ethical and Religious Perspectives from India in a Global Context, 30 Psychology, Health & Med. 2245 (2025).

[22]Bhavin Chavan & Siddharth Patra, Euthanasia: Evolving Role of the Psychiatrists in India, 54 Indian J. Psychiatry 108 (2012).

[23]Aman Gupta & Deepa Bansal, Euthanasia Review and Update Through the Lens of a Psychiatrist, 32 Indus. Psychiatry J. 15 (2023); Ankit Dwivedi, Reframing End-of-Life Jurisprudence, Sortuz: Oñati J. Emergent Socio-Legal Stud. (2025), https://doi.org/10.35295/sz.iisl/2379.

[24]Luisa Vañó et al., Comparative Legal and Bioethical Perspectives on Euthanasia and Assisted Suicide: A Systematic Review of European Frameworks, BMC Med. Ethics (2026), https://doi.org/10.1186/s12910-026-01410-w.

Second Doctrinal Case Law Analysis. The paper examines the judicial reasoning in *ECLI:NL:HR:2020:712*, *Pretty v. United Kingdom*, *Haas v. Switzerland*, *Mortier v. Belgium*, *Common Cause v. Union of India*, and *Aruna Ramchandra Shanbaug v. Union of India*[25] Interrogating not only what these courts decided but how they reasoned, identifying in particular the points at which courts substituted deference to medical opinion for independent legal reasoning.

Third Synthesis of Neuroscientific Literature. The paper synthesises the relevant neuroscientific literature on psychiatric irremediability, neurodegeneration, prefrontal-limbic circuitry, and decisional capacity to establish the precise boundary of what neuroscience can and cannot currently tell a court. The synthesis is drawn from a systematic literature review across a corpus of over 87,991,504 papers using the Consensus AI-assisted research platform, incorporating sources from Semantic Scholar and PubMed, screened across six thematic categories to yield 50 included papers. [26]

Fourth Normative Legal Analysis. The paper's ultimate methodological register is normative it argues for what courts *should* do, grounded in established legal principles of rule of law, proportionality, constitutional dignity, and human rights compliance. The normative analysis draws on Articles 2 and 8 ECHR, Article 21 of the Constitution of India as interpreted in *Common Cause*, the *parens patriae* doctrine as applied in *Aruna Shanbaug*, the *Mental Healthcare Act, 2017*, and the Appelbaum-Grisso four-component model of decisional capacity [27] not as a clinical tool, but as a legal standard for evaluating expert testimony in a structured and principled way.

C. Research Objectives

Objective 1: To expose the structural inadequacy of existing euthanasia frameworks when applied to psychiatric claims particularly the combination of indeterminate irremediability standards, unstable capacity assessments, and judicial deference to divided clinical opinion that is constitutionally untenable when the act authorised is irreversible.

Objective 2: To establish what neuroscience can and cannot contribute to judicial determinations of psychiatric irremediability identifying specific neurological findings associated at the group level with severe psychiatric disorder while establishing that they remain probabilistic and cannot establish individual irremediability with the certainty an irreversible judicial act requires.

Objective 3: To articulate the four pillars of a judicially operable neuro-legal framework designed not as a medical protocol but as a structure of legal reasoning, derived from existing legal principles, augmented by neuroscientific and psychiatric evidence, and calibrated to the institutional capacity of courts.

Objective 4: To ground the framework in India's constitutional, legislative, and infrastructural context including 1.9 million hospital beds for a population exceeding 1.4 billion, [28] a treatment gap of 70–92% for mental health disorders, [29] 0.75 psychiatrists per 100,000 population against

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

[26]See supra note 3 (describing the systematic literature review methodology).

[27]Paul S. Appelbaum & Thomas Grisso, Assessing Patients' Capacities to Consent to Treatment, 319(25) New Eng. J. Med. 1635 (1988).

[28]Manish Kapoor et al., Critical Care in India: Present and Future, Indian J. Crit. Care Med. (2020).

[29]National Institute of Mental Health and Neurosciences (NIMHANS), National Mental Health Survey of India, 2015–16 88 (2016) [hereinafter NMHS 2016] (reporting 70–92% treatment gap).

the WHO-recommended minimum of three, [30] and 14,305 mental illness–linked suicides in 2024 alone. [31]

Objective 5: To address the conceptual distinction between legally cognisable psychiatric suffering and non-justiciable existential distress.

Objective 6: To formulate open research questions that future empirical scholarship must address before any Indian legislative reform can responsibly proceed addressing decisional capacity assessment in Indian patients, culturally sensitive guidelines for a collectivist social context, and the infrastructure gap in palliative and psychiatric care.

COMPARATIVE AND CRITICAL ANALYSIS

A. The Transplant Problem

Before the comparative exercise begins, a structural observation demands attention: the frameworks adopted by the Netherlands, Belgium, and Canada were not *designed* for psychiatric euthanasia they were designed for somatic euthanasia and then *extended* by legislative amendment, committee practice, or judicial interpretation to cover psychiatric suffering. Extending a legal framework is not the same as designing one. When you extend a framework, you assume the underlying evidentiary logic travels. In somatic euthanasia, it does. But psychiatric suffering does not share these properties extending a somatic framework to psychiatric claims is, to borrow a surgical analogy, like transplanting a kidney into a cardiac cavity. [32] The organ is functional in its native environment but produces systemic rejection in a radically different one.

B. The Netherlands: Retrospective Review and the Due-Care Trap

1. Statutory Architecture and Its Structural Vulnerability

The *Termination of Life on Request and Assisted Suicide (Review Procedures) Act, 2002* establishes due-care criteria that, if met, exempt a physician from criminal prosecution requiring that the patient's request be voluntary and well-considered, that suffering be unbearable without prospect of improvement, that the patient be fully informed, and that a second independent physician be consulted. All cases must be reported to Regional Euthanasia Review Committees (RTEs) for retrospective assessment. The architecture appears robust. But it contains a structural vulnerability that becomes catastrophic in the psychiatric context: the primary safety mechanism is retrospective. The physician acts first; the committee reviews afterward. In psychiatric cases, the patient is already dead. The committee cannot verify whether the irremediability assessment was reliable, whether capacity was genuinely stable at the time of consent, or whether all treatment alternatives were genuinely exhausted. [33] The retrospective model in psychiatry is, functionally, a rubber stamp on an act that cannot be undone.

2. The Irremediability Crisis

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[30]Kiran Garg, C.N. Kumar & Prabha S. Chandra, Number of Psychiatrists in India: Baby Steps Forward, but a Long Way to Go, 61(1) Indian J. Psychiatry 104, 105 (2019).

[31]NCRB 2024, supra note 1, at 21–23.

[32]De Hert & Van Assche, supra note 5 (arguing that the somatic evidentiary logic underlying Dutch and Belgian euthanasia regimes is structurally incompatible with the epistemological character of psychiatric claims).

[33]S.H. Bosma et al., The Dutch Practice of Euthanasia and Assisted Suicide in Patients Suffering from Psychiatric Disorders: A Qualitative Case Review Study, 15 Frontiers Psychiatry (2024), https://doi.org/10.3389/fpsyt.2024.1452835; Miller & Kim, supra note 35 (documenting cases that did not meet due-care criteria retrospectively reviewed by the RTE).

The most consequential failure of the Dutch framework in its psychiatric application is the operationalisation of irremediability. In oncology, irremediability can be established by reference to tumour staging and peer-reviewed prognosis tables. In psychiatry, the word has no equivalent anchor there are over 150 conflicting clinical definitions of treatment-resistant depression alone, [34] the single most frequently cited diagnosis in Dutch psychiatric euthanasia cases. Courts routinely require forensic experts to apply a *Daubert* or *Frye* standard before admitting scientific evidence. No equivalent gatekeeping standard has been applied to psychiatric irremediability assessments in Dutch euthanasia practice physicians are permitted to certify irremediability using clinical intuition rather than validated methodology, and committees retrospectively defer to that intuition. [35] A court that would demand rigorous validation before admitting DNA evidence has, in the euthanasia context, accepted expert opinion that would be inadmissible in any other capital-consequence adjudication.

3. ECLI:NL:HR:2020:712 The Coffee Euthanasia Case

The Dutch Supreme Court's 2020 ruling [36] is the most consequential judicial demonstration of this gap. The case involved a patient with advanced Alzheimer's who had executed an advance euthanasia directive while competent. The physician administered euthanasia after sedating the patient, who had expressed resistance at the time of administration, relying on the prior directive rather than contemporaneous consent. The Court upheld the acquittal, reasoning that a written advance directive may substitute for contemporaneous consent when the patient has lost capacity. This reasoning is doctrinally coherent for advanced dementia where cognitive degeneration is linear, progressive, and verifiable and constitutionally alarming when extended to psychiatry. In psychiatric disorders, capacity is not a steady declining curve that eventually reaches zero. It is a fluctuating variable. The Dutch Supreme Court's logic, transposed into that context, risks treating the preferences of the incapacitated self as an irrevocable mandate against the preferences of a potentially recoverable one.

C. Belgium: Twenty-Three Years of Documented Drift

1. The Statutory Promise and the Criterion Collapse

The Belgian *Euthanasia Act, 2002* is textually more sophisticated than its Dutch counterpart in its accommodation of psychiatric claims, requiring a written and dated request, mandatory consultation with an independent psychiatrist, an extended one-month waiting period, and reporting to the Federal Control and Evaluation Committee on Euthanasia (FCECE). After twenty-three years of operation, however, the Belgian framework has produced a documented pattern of systemic failures. [37] Verhofstadt et al.'s 2024 qualitative interview study of Belgian mental healthcare professionals [38] found that while 'unbearable suffering' is regarded as the

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[34]Kim et al., supra note 7, at 362–63; Bahji & Delva, supra note 15, at 930 (both noting the absence of a uniform, validated definition of treatment-resistant depression and the clinical and legal difficulty this creates for irremediability assessments).

[35]Dieuwke Miller & Scott Y.H. Kim, Euthanasia and Physician-Assisted Suicide Not Meeting Due Care Criteria in the Netherlands: A Qualitative Review of Review Committee Judgements, 7 BMJ Open (2017), https://doi.org/10.1136/bmjopen-2017-017628.

[36]Coffee Euthanasia Case, supra note 19.

[37]Jochen Vandenberghe, Lessons from Belgium: Physician-Assisted Dying for (Neuro)Psychiatric Suffering After 23 Years of Belgian Euthanasia Legislation, 68 Eur. Psychiatry S65 (2025), https://doi.org/10.1192/j.eurpsy.2025.195.

[38]Miet Verhofstadt et al., Perspectives on the Eligibility Criteria for Euthanasia for Mental Suffering Caused by Psychiatric Disorder Under the Belgian Euthanasia Law: A Qualitative Interview Study Among Mental Healthcare Workers, 93 Int'l J.L. & Psychiatry 101961, 4–7 (2024).

most clearly understood criterion, the remaining due-care requirements irremediability, no reasonable treatment alternative, and competence are frequently misunderstood, inconsistently applied, or operationally impossible to verify. Irremediability was interpreted along a spectrum ranging from 'all biological treatments have been tried' to 'the patient themselves believes no further treatment is meaningful' a spectrum so wide that the criterion functions more as rhetorical validation than substantive gatekeeping.

Belgian professional bodies have responded by issuing stricter deontological guidance than the statute requires. But deontological guidance is not law. It cannot be enforced by courts. The result is what Raus et al. have called a 'dual-track' system: a permissive statute and a stricter professional norm that practitioners may choose to follow or not. [39]

2. The Criminal Case and What It Reveals

The first Belgian criminal prosecution for psychiatric euthanasia [40] in which the physician was acquitted revealed that the criminal court, lacking any statutory standard against which to assess fundamental disagreements among consulting experts about the validity of the irremediability assessment, resolved the evidentiary gap by falling back on the lowest common denominator: if the statutory procedural steps were followed, the due-care requirement was met. This outcome is constitutionally perverse. It means that compliance with *process* ticking the boxes of consultation and waiting periods is treated as equivalent to compliance with *substance.* Actus reus displaces mens rea. That is precisely the mistake a neuro-legal framework must refuse to make.

3. Mortier v. Belgium: Conditional Blessing, Not Constitutional Validation

The ECHR's decision in *Mortier v. Belgium*[41] is frequently cited as evidence that the existing framework is Convention-compliant. This reading is technically accurate and strategically misleading. The Court did not hold that Belgian psychiatric euthanasia, as structurally designed, satisfies the Article 2 positive obligation. It held that the *specific case* before it did not disclose a violation, in part because the applicant could not demonstrate that his mother's death was causally connected to a specific procedural failure. What *Mortier* establishes read alongside *Pretty* and *Haas* is a *conditional* permission: a state may permit psychiatric euthanasia if and only if its procedural safeguards are sufficiently robust to discharge the Article 2 positive obligation. The Strasbourg jurisprudence does not certify that Belgium's safeguards are sufficient it declines, on the facts before it, to find that they are insufficient. The distinction between constitutional validation and constitutional non-condemnation is not pedantic it is the difference between a framework that passes muster and one that has simply not yet been struck down.

D. Canada: Judicial Caution as Inadvertent Constitutional Wisdom

The Canadian trajectory offers the most instructive comparative lesson. In *Carter v. Canada (Attorney General)*[42], the Supreme Court struck down the blanket criminal prohibition on physician-assisted dying as a violation of section 7 of the *Canadian Charter of Rights and Freedoms.* Subsequent legislation Bill C-14 (2016) and Bill C-7 (2021) progressively expanded

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[39]Kasper Raus, Bert Vanderhaegen & Sigrid Sterckx, Euthanasia in Belgium: Shortcomings of the Law and Its Application and of the Monitoring of Practice, 46(1) J. Med. & Phil. 80, 80 (2021).

[40]Marc De Hert, Stefan Loos, Sigrid Sterckx, Erik Thys & Kris Van Assche, Improving Control Over Euthanasia of Persons with Psychiatric Illness: Lessons from the First Belgian Criminal Court Case Concerning Euthanasia, 13 Frontiers Psychiatry (2022), https://doi.org/10.3389/fpsyt.2022.933748.

[41]Mortier, App. No. 78017/17; Pretty, App. No. 2346/02, ¶ 39; Haas, App. No. 31322/07.

[42]Carter, [2015] 1 SCR 331, ¶¶ 55–57 (Can.).

MAiD eligibility. But the extension of MAiD to mental illness as a sole underlying condition has been repeatedly deferred: initially until March 2023, then March 2024, then March 2027, [43] with each deferral explicitly predicated on the legislature's recognition that the evidentiary standards do not yet exist to reliably identify psychiatric patients for whom death is the appropriate response rather than enhanced treatment. Canada has, in effect, enacted the structural argument of this paper by legislative default: the absence of reliable psychiatric irremediability criteria is a foundational legal problem that must be solved before authorisation can responsibly proceed. Judicial caution about evidentiary reliability in irreversible decisions is not paternalism it is constitutionalism.

E. India: The Constitutional Vacuum and Its Structural Consequences

1. What Common Cause Authorised and What It Left Open

The Supreme Court's decision in *Common Cause v. Union of India*[44] constitutionally entrenched the right to die with dignity as a dimension of Article 21, established a framework for passive euthanasia via Primary and Secondary Medical Boards with JMFC intimation, and recognised advance directives as legally valid instruments of end-of-life preference. What the Court explicitly did not and could not do is establish any framework for psychiatric euthanasia. The judgment addresses terminal somatic illness and persistent vegetative state; it says nothing about treatment-resistant psychiatric disorders, fluctuating decisional capacity, or the epistemological problem of diagnosing unbearable suffering in a patient whose disorder impairs their own self-evaluation. The constitutional architecture is sound: Article 21 as interpreted in *Common Cause* is capacious enough to accommodate the right of a patient with genuinely irremediable psychiatric suffering to die with dignity. But constitutional capacity is not the same as operational framework. The Court has opened a door it has not built the corridor beyond it.

2. The parens patriae Doctrine and Its Psychiatric Limitations

The *parens patriae* doctrine as deployed in *Aruna Shanbaug*[45] offers a partial bridge it allows courts to act on behalf of permanently incapacitated persons in their best interests. But its formulation in Indian law has a critical flaw in the psychiatric context: it is *medically deferential* rather than evidentially structured. The Shanbaug Court accepted the treating hospital's assessment as the primary basis for its determination without establishing any independent evidentiary standard. Extend this doctrine to psychiatric euthanasia where clinical opinion is not merely one-sided but internally divided and *parens patriae* becomes not a protection for the vulnerable patient but a mechanism for transferring decisional authority from the patient to the clinician, without judicial review of whether that authority is being responsibly exercised.

3. The Infrastructure Argument: When Absence of Care Manufactures Euthanasia Requests

Any honest comparative analysis of India's position must confront an uncomfortable structural fact: a significant proportion of euthanasia requests somatic or psychiatric arise not from genuinely irremediable suffering but from the absence of adequate care. In India, where 70–92% of people with mental disorders receive no treatment, [46] where there are 0.75 psychiatrists per 100,000 population against the WHO-recommended minimum of three, [47] and where

[43] Bahji & Delva, supra note 15, at 929–32.

[44] Common Cause, (2018) 5 SCC 1, ¶¶ 198–210 (India) (Chandrachud, J., concurring).

[45] Aruna Ramchandra Shanbaug v. Union of India, (2011) 4 SCC 454 (India); supra note 25.

[46] NMHS 2016, supra note 29, at 88 (reporting 70–92% treatment gap for mental disorders in India).

[47] Garg, Kumar & Chandra, supra note 30, at 105.

critical care infrastructure is strained across 1.9 million hospital beds for a population exceeding 1.4 billion, [48] the risk that a psychiatric euthanasia request reflects not irremediability but inadequacy of care is structurally elevated. A patient who requests death because they are in unmanaged pain is not making an autonomous choice they are responding to a clinical failure. A neuro-legal framework that does not account for infrastructure-constrained irremediability is not a safeguard it is a mechanism for laundering inadequate healthcare into legally authorised death.

F. India's Civilisational Framework

The Jain doctrine of *Sallekhana* protected as a religious practice by Indian courts [49] and the Hindu concept of *Prayopavesa* [50] collectively demonstrate that within India's own jurisprudential heritage, the binary between 'protecting life' and 'permitting chosen death' was never absolute. Crucially, neither tradition authorises death on the basis of suffering alone. Both require a situated, community-observed, and purposively calibrated judgment that the conditions for continued meaningful existence no longer obtain voluntariness without distortion, communal (here, multidisciplinary) oversight, and genuine exhaustion of all meaningful alternatives. In spirit if not in form, the neuro-legal framework this paper proposes is more consistent with India's own civilisational inheritance than either the Dutch retrospective deference model or the Belgian criteria-drift regime.

G. Comparative Tables

Table 1: Comparative Legal Frameworks for Psychiatric Euthanasia Structural Features and Identified Deficiencies

Jurisdiction	Legal Basis	Psychiatric Eligibility	Evidentiary Standard	Critical Failure Point
Netherlands	WTL 2002	Permitted; committee practice (no explicit statutory provision)	Due-care, retrospective RTE review; voluntary, well-considered request; unbearable suffering without prospect of improvement	Retrospective review normalises clinical over judicial scrutiny; >150 competing TRD definitions render irremediability unfalsifiable
Belgium	Euthanasia Act 2002 (non-terminal extension)	Explicitly permitted; mandatory psychiatrist consultation + one-month	Written request; 2–3 physician involvement; Federal Commission (FCECE)	Criteria inconsistently interpreted; deontological rules stricter than statute but legally

[48]Kapoor et al., supra note 28.

[49]Naresh Kadyan v. Union of India, Writ Petition No. 855 of 2015 (Rajasthan H.C., India) (stayed by Supreme Court of India, Aug. 31, 2015); supra note 20.

[50]Paul et al., supra note 21, at 2248–49 (discussing Hindu doctrinal traditions of consciously chosen death including Prayopavesa and their potential resonance with contemporary end-of-life law).

		waiting period for non-terminal cases	oversight a posteriori	unenforceable; criteria-drift documented across 23 years
Canada	Carter v. Canada [2015] + C-7/C-62 amendments	Deferred; mental disorder as sole criterion postponed until at least March 2027	Constitutional scrutiny; 'grievous and irremediable'; independent practitioner assessment	Legislative paralysis reflects de facto recognition that somatic evidentiary logic cannot be transplanted to psychiatry without architectural redesign
India	Common Cause v. Union of India (2018) 5 SCC 1	None; passive euthanasia only; Primary + Secondary Medical Board; JMFC intimation	Terminal illness or PVS; no framework for psychiatric suffering whatsoever	Total legislative and judicial vacuum; 14,305 mental illness–linked suicides annually (NCRB 2024) without any cognisable legal framework

Table 2: Fault-Lines in Judicial Reasoning Landmark Decisions on Psychiatric and Cognitive Euthanasia

Case	Court / Year	Core Holding	Doctrinal Fault-Line
ECLI:NL:HR:2020:712 ('Coffee Euthanasia')	Dutch Supreme Court, 2020	Advance euthanasia directive substitutes contemporaneous consent in advanced dementia; physician may proceed despite patient resistance at time of administration	Court privileges prior narrative identity over present experiential interests. Transposed to psychiatry where capacity fluctuates rather than linearly degenerates this logic risks authorising death on the basis of an earlier autonomous self who may no longer represent the patient's current will.
Pretty v. United Kingdom, App. No. 2346/02 (2002)	ECtHR (Grand Chamber)	Article 2 ECHR does not confer a right to die; state's positive	The categorical Article 2 position has been progressively softened

		obligation is to protect life	by Haas and Mortier without a principled reconciliation framework. The tension between Articles 2 and 8 remains unresolved where vulnerability and autonomy coexist in the same patient.
Haas v. Switzerland, App. No. 31322/07 (2011)	ECtHR	Article 8 encompasses the right to decide the manner and time of one's death; wide margin of appreciation for states	Deferring to national margin without specifying minimum evidentiary standards for psychiatric cases creates a procedural floor too low to discharge positive obligations under Article 2 when applied to fluctuating decisional capacity.
Mortier v. Belgium, App. No. 78017/17 (2022)	ECtHR	Belgian psychiatric euthanasia as practiced did not per se violate ECHR; procedural safeguards must be robust enough to discharge Article 2 positive obligations	The 'as practiced' qualification converts a constitutional guarantee into a process-compliance question, leaving courts to defer to medical opinion rather than independently assessing whether the evidentiary threshold was legally adequate.
Common Cause v. Union of India, (2018) 5 SCC 1	Supreme Court of India	Right to die with dignity is a facet of Article 21; passive euthanasia authorised; advance directives recognised subject to Medical Board oversight	Constitutional architecture sound but limited to somatic suffering. No capacity assessment protocol for fluctuating mental states; no irremediability standard for psychiatric illness; no judicial threshold for neurobiological evidence.

Aruna Ramchandra Shanbaug v. Union of India, (2011) 4 SCC 454	Supreme Court of India	Parens patriae allows courts to act on behalf of permanently incapacitated persons; passive euthanasia permitted with High Court approval	The parens patriae doctrine is purely medically deferential the Court accepts the treating hospital's assessment without an independent evidentiary standard. Extended to psychiatric euthanasia where clinical opinion is divided, this creates no structural protection against authorising death on contested expert opinion.

Table 3: Evidentiary Standards Somatic Euthanasia, Current Psychiatric Practice, and the Neuro-Legal Framework

Dimension	Somatic Euthanasia	Psychiatric Euthanasia (Current Practice)	What the Neuro-Legal Framework Demands
Irremediability	Demonstrable by scan, biopsy, oncology staging objectively verifiable	Contested expert opinion; >150 conflicting TRD definitions; prognosis inherently probabilistic	Documented exhaustion of all evidence-based treatment modalities with longitudinal record; neurobiological corroboration of structural/functional deterioration where available
Decisional Capacity	Typically preserved; standard Appelbaum-Grisso assessment sufficient	Fluctuates with the very illness being evaluated the assessor and assessed are caught in the same epistemological loop	Longitudinal, multi-point assessment over minimum defined period; capacity evaluated during periods of relative stability; independent panel including non-treating psychiatrist
Suffering	Objectively evidenced by clinical trajectory, pain scores, organ function indices	Phenomenological; subjective; not externally verifiable; conflated with	Diagnosable, neurobiologically associated psychiatric disorder refractory to treatment

		existential distress in practice	distinguished from non-clinical existential suffering without verifiable pathological basis
Judicial Role	Oversight of established medical consensus; deference is constitutionally tolerable	Clinical opinion is itself divided; deference becomes abdication of the court's constitutional function	Active proportionality review; structured evaluation of expert testimony; refusal to authorise on divided or unsupported clinical opinion alone

H. Four Structural Deficiencies Common to All Existing Frameworks

1. Indeterminate Irremediability. No jurisdiction examined has established a judicially workable definition of irremediability for psychiatric disorders. Unlike somatic conditions where irremediability can be verified against objectively observable pathological progression psychiatric irremediability involves a judgment about the ceiling of a treatment discipline that is itself internally contested. [51] A court that authorises death on the basis of an irremediability determination that no existing standard can validate has not applied the law it has substituted clinical authority for legal judgment without acknowledging the substitution.

2. Unstable Capacity Assessment. Every existing framework applies some version of the Appelbaum-Grisso four-component model. [52] The model was designed for point-in-time clinical assessment not for legal proceedings where the very faculties assessed may be distorted by the illness at the moment of assessment while being intact at another. A single capacity assessment is a snapshot of a fluctuating variable. A legal standard that treats a snapshot as a reliable measure of a continuous state has confused the instrument for the phenomenon. [53]

3. Judicial Deference as Constitutional Abdication. Across every jurisdiction examined, courts have progressively retreated from independent evidential assessment and delegated it to clinical opinion while masking this incapacity as 'deference to expertise.' Deference to expertise is constitutionally legitimate when expert consensus is reliable, uncontested, and externally verifiable. In psychiatric euthanasia, none of these conditions obtains. A court that defers to divided, unvalidated, phenomenologically grounded clinical opinion has not exercised judicial restraint it has abdicated its constitutional function as the institutional guardian of the right not to be killed by the state on inadequate evidence.

4. The Missing Proportionality Gateway. No existing framework applies proportionality review to the individual psychiatric euthanasia determination in the sense that constitutional law demands. Proportionality analysis requires asking: have all less-drastic alternatives been genuinely exhausted? Is the evidence of irremediability sufficiently reliable to justify an irreversible act? Is the patient's suffering of a kind that is legally cognisable rather than

[51] Kim et al., supra note 7; De Hert & Van Assche, supra note 5; Bahji & Delva, supra note 15, at 930 (all identifying the absence of a judicially workable irremediability standard as the central deficiency of psychiatric euthanasia frameworks).

[52] Appelbaum & Grisso, supra note 27.

[53] De Hert & Van Assche, supra note 5 (arguing that a single capacity assessment cannot substitute for longitudinal evaluation in a patient whose decisional faculties fluctuate with the course of illness); Verhofstadt et al., supra note 38, at 6.

existentially unbearable but clinically addressable? [54] The neuro-legal framework proposed in Part V provides precisely this gateway not as a bureaucratic hurdle but as the constitutional minimum that an irreversible judicial act demands.

LOOPHOLES IN INDIAN LAW AND THE CASE FOR A NEURO-LEGAL FRAMEWORK

A. The Anatomy of a Legal Vacuum

Indian law on euthanasia and psychiatric suffering is, at present, a dense cluster of loopholes the statutes speak past each other, the case law addresses adjacent territory without mapping the centre, and the constitutional text is capacious enough to accommodate an answer without any institutional actor yet being asked to derive one. The result is not a principled prohibition of psychiatric euthanasia it is an accidental one, produced not by deliberate policy but by the accumulated inertia of doctrines developed for different problems. [55] Indian law, as currently constituted, *cannot* coherently answer a psychiatric euthanasia claim when presented with one and this incoherence is itself a violation of the rule of law's demand for determinate legal standards in matters of life and death.

Table 4: Indian Statutory and Doctrinal Gaps Psychiatric Euthanasia

Statutory Provision	Stated Scope	Loophole / Gap for Psychiatric Euthanasia
Art. 21, Constitution of India Right to Life and Personal Liberty	Common Cause (2018) extends to passive euthanasia for terminal somatic illness / PVS only	No constitutional ceiling prevents extension to psychiatric irremediability; the dignity reasoning is organism-agnostic yet no court has been petitioned to apply it to psychiatric suffering. The silence is procedural, not doctrinal.
Mental Healthcare Act 2017, S. S. 3, 5, 17–18	Presumed capacity; advance directives for mental healthcare; right to refuse treatment	Section 5 advance directives operate only for treatment refusal not euthanasia authorisation. The gap between 'refusing treatment' and 'requesting death' is legally unbridged. A patient may refuse ECT under the MHA; they cannot request PAD under any statute.
BNS S. 226 / IPC S. 309 Attempt to Commit Suicide	MHA 2017 S. 115 mandates care-and-treatment approach, softening the offence	The MHA carve-out treats suicidality as a medical symptom requiring treatment not as a potential expression of autonomous end-of-life choice. This produces a paradox: the law simultaneously says a suicidal person is mentally ill (and thus non-autonomous) and that their autonomy is presumed (S. 3 MHA).
BNS S. 108 / IPC S. 306 Abetment of Suicide	Criminalises any assistance in suicide,	No physician exception analogous to the Belgian or Dutch model. A psychiatrist

[54]Manuel Trachsel & Ralf Jox, Suffering Is Not Enough: Assisted Dying for People with Mental Illness, 36 Bioethics 519, 521 (2022).

[55]K. Gopalan & A.G., Exploring Euthanasia: A Comparative Legal Analysis of India's Constitutional Approach and Global Practices, J. Pioneering Med. Sci. (2025), https://doi.org/10.47310/jpms2025140917.

	including by physicians	who assists a patient's death even after years of documented futility commits an offence. The law cannot accommodate the difference between culpable abetment and medically authorised assisted dying.
Common Cause 2018 Medical Board Structure	Primary Medical Board + Secondary Medical Board + JMFC intimation	Board composition mandates 'registered medical practitioners' no psychiatric expertise requirement. A psychiatric euthanasia claim would be evaluated by a board structurally designed for somatic assessment. JMFC receives intimation but has no evidentiary review role.
MHA 2017, S. 23 Mental Health Review Boards	MHRBs adjudicate admission, treatment, and discharge disputes	MHRBs have no jurisdiction over end-of-life decisions. They are welfare tribunals not courts of competent jurisdiction for an irreversible act. The institutional gap between what MHRBs do and what psychiatric euthanasia demands is total.
Parens Patriae Doctrine Aruna Shanbaug (2011)	Courts may act in the best interests of permanently incapacitated persons; treating hospital's assessment is primary evidence	The doctrine is medically deferential without an independent evidentiary standard. In psychiatric euthanasia, where clinical opinion is internally divided, parens patriae without a structured framework becomes a rubber stamp on whichever clinician reaches the court first.

Key Loopholes Anatomised

1. The Article 21 Extension Problem

In *Common Cause*[56], Justice Chandrachud grounded the right to die with dignity in the proposition that the right to live with dignity necessarily encompasses the right to ensure that one's dying is not stripped of it. The reasoning is organism-agnostic: dignity is a property of personhood, not of the body. A person whose personhood is being dismantled not by cancer but by the architecture of their own mind has no less a claim to Article 21. The loophole is this: the *Common Cause* framework operationally confines itself to somatic pathology and PVS because those were the facts before the Court. There is no doctrinal reason, derived from the Court's own reasoning, why the same constitutional logic cannot extend to psychiatric irremediability but there is also no judicial decision, legislative instrument, or procedural scaffold that makes that extension available. A right that cannot be exercised is, functionally, no right at all.

2. The Mental Healthcare Act 2017: A Rights Statute That Cannot Reach the End of Life

The *Mental Healthcare Act, 2017* [57] is the most progressive psychiatric legislation India has produced. Section 3 establishes a statutory presumption of capacity; Section 5 recognises advance directives; Section 29 protects the right to live in the community. Together, these

[56]Common Cause, supra note 2, ¶¶ 196–211 (Chandrachud, J., concurring) (grounding the right to die with dignity in the proposition that Article 21 is organism-agnostic: dignity is a property of personhood, not of biological substrate).

[57]Mental Healthcare Act, No. 10 of 2017 [MHA], §§ 3, 5, 17–18 (India).

provisions represent a coherent rights-based framework for psychiatric care and they collectively stop precisely at the threshold of end-of-life decision-making. [58] The consequence is a doctrinal paradox: the law says this patient has capacity (S. 3) and may express preferences about their medical care in advance (S. 5), but it simultaneously provides no lawful avenue through which those preferences if they tend toward death can be given effect. Capacity without remedy is not autonomy it is a well-lit corridor ending in a locked door.

3. The Suicide Criminalisation Paradox: BNS S. 226 / IPC S. 309

The *Bharatiya Nyaya Sanhita, 2023* retains the criminalisation of attempted suicide under Section 226, [59] while the MHA simultaneously mandates that a person who attempts suicide shall be presumed to be under severe stress and shall not be tried or punished. The MHA's medicalisation of suicidality produces a doctrinal trap: if the law applies the MHA's logic consistently suicidal ideation is a symptom of illness, not autonomous choice then any request for assisted dying from a psychiatric patient can be characterised as symptomatic rather than volitional. The law cannot simultaneously say that a psychiatric patient's suicidality is a symptom to be treated and that the same patient's persistent, longitudinally assessed, post-treatment request to die is an exercise of autonomous will deserving legal recognition. [60] Unless this paradox is resolved by drawing the legal distinction between acute suicidal ideation generated by untreated illness and the persistent post-treatment request of a genuinely irremediable patient, Indian courts have no principled basis for evaluating a psychiatric euthanasia claim at all.

4. BNS S. 108 / IPC S. 306 Abetment: The Physician in the Criminal Frame

Section 108 BNS (formerly Section 306 IPC) criminalises abetment of suicide with no statutory physician exception. A psychiatrist who, after years of documented treatment futility, assists a patient's death even pursuant to a court order that the current law cannot produce commits an offence. The Dutch and Belgian legislative models address this gap precisely: the WTL 2002 and the Belgian *Euthanasia Act, 2002* each create statutory exemptions from criminal liability for physicians who comply with due-care criteria. [61] Indian law has no equivalent. Legislative amendment carving out a medically sanctioned physician exception is not optional it is a constitutional precondition for any viable psychiatric euthanasia framework in India.

5. The Medical Board's Missing Psychiatrist

The *Common Cause* framework mandates a Primary Medical Board composed of registered medical practitioners and a Secondary Medical Board led by the Chief Medical Officer of the district neither with any mandatory psychiatric member. [62] In psychiatric euthanasia, the diagnosis is the contested question and the capacity is the legally critical variable. The one professional category whose expertise is indispensable has no structural role in the only oversight mechanism the law currently provides. This requires structural reform of the Board's composition mandate and specification of the evidentiary weight to be assigned to psychiatric expert opinion within the Board's deliberations.

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[58]MHA § 3(1) (India) ('Every person shall be presumed to have capacity to make mental healthcare and treatment decisions.'); MHA § 5 (advance directive provision).

[59]Bharatiya Nyaya Sanhita, No. 45 of 2023, § 226 (India); Indian Penal Code, No. 45 of 1860, § 306 (India).

[60]P. Rathinam v. Union of India, (1994) 3 SCC 394 (India); Gian Kaur v. State of Punjab, (1996) 2 SCC 648, ¶¶ 22–24 (India).

[61]Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding [WTL] (Neth. 2002), art. 2(1) (exempting the physician from criminal liability upon compliance with due-care criteria); Wet betreffende de euthanasie [Belgian Euthanasia Act] (Belg. 2002), art. 3(1) (same). Supra note 4.

[62]Common Cause, supra note 2, ¶¶ 220–228 (prescribing the Primary Medical Board and Secondary Medical Board compositions for passive euthanasia; no mandatory psychiatric expertise requirement appears in the framework).

6. JMFC Intimation vs. Judicial Review: The Oversight That Isn't

The *Common Cause* framework requires 'intimation' to the Judicial Magistrate First Class not authorisation, not review, not adjudication. The JMFC receives a copy of the Secondary Medical Board's decision. In passive somatic euthanasia, this is a tolerable design. In psychiatric euthanasia, where the Board's findings will be contested, expert opinion will be divided, and the act being authorised is both irreversible and constitutionally contested, intimation is constitutionally insufficient. The difference between JMFC intimation and judicial review is the difference between a court being *told* what was done and a court being asked to *evaluate* whether it should be done. For an irreversible act raising fundamental rights questions under Articles 14 and 21, the minimum standard is a judicial proceeding with adversarial input and reasoned output not a form filed with a magistrate who has no power to act on it.

V. THE PROPOSED NEURO-LEGAL FRAMEWORK: FOUR PILLARS FOR JUDICIAL ADJUDICATION

A. Architecture of the Framework

The framework proposed here is not a medical protocol it is a structure of legal reasoning. Just as courts have developed structured evidentiary frameworks for DNA forensics, digital evidence, and toxicological testimony without becoming scientists, this paper asks courts to become sophisticated evaluators of psychiatric and neurological evidence without becoming clinicians. The analogy is direct: a judge evaluating a ballistics report does not need to know how to fire a gun they need to know what makes a ballistics conclusion reliable, what the error rate of the method is, and how it should be weighed against contradicting evidence. The same standard applies to psychiatric irremediability assessments in euthanasia adjudication. [63]

The framework has four pillars. Each addresses a specific structural failure identified in the comparative and doctrinal analysis. Each is grounded in an existing legal principle no new constitutional authority is required. And each is calibrated to the institutional reality of Indian courts, the infrastructure constraints of the Indian healthcare system, and the cultural context in which any framework must operate. Critically, the four pillars are sequential, not alternative: a psychiatric euthanasia claim must satisfy all four before a court may authorise the act. The failure of any single pillar is independently dispositive.

Table 5: The Four-Pillar Neuro-Legal Framework Standards, Bases, and Sources

Pillar	Legal Basis (Indian)	Operational Standard	Informed By
I Neurobiological Substantiation	Art. 21 (dignity-based irreversibility threshold); Common Cause ¶ 202 (Chandrachud J.)	(a) DSM-5/ICD-11 diagnosis by board-certified psychiatrist; (b) neuroimaging (fMRI/PET) corroborating structural/functional abnormality consistent with diagnosis; (c) documented treatment history spanning ≥5 years with exhaustion of all evidence-based protocols pharmacotherapy,	De Hert & Van Assche (2024); Grassi et al. (2022); Canadian MAiD Track 2 assessment model

[63] Scopetti et al., supra note 8 (arguing for structured evidentiary frameworks that enable courts to evaluate expert psychiatric opinion without requiring clinical competence); De Hert & Van Assche, supra note 5.

		psychotherapy, ECT/rTMS, and where accessible ketamine/esketamine. Neuroimaging is probative, not conclusive: it shifts the burden of rebuttal to the State.	
II Longitudinal Decisional Capacity Assessment	MHA 2017 S. 3 (presumed capacity); Appelbaum-Grisso four components as judicial evidentiary standard; Art. 21 (autonomy)	Capacity assessed by two independent, non-treating psychiatrists at minimum three time points spanning ≥6 months, using the Appelbaum-Grisso four components (understanding, appreciation, reasoning, expression) as a structured evidentiary template not a clinical checklist. Capacity assessed during periods of relative clinical stability. Any fluctuation must be disclosed to the court and triggers re-evaluation, not automatic denial.	Appelbaum & Grisso (1988); Verhofstadt et al. (2024); Belgian two-psychiatrist deontological requirement; MHA 2017 S. 3
III Disorder-Specific Eligibility Criteria	Common Cause (irremediability standard); MHA S. 3 (non-discrimination); Art. 14 (equality)	Eligibility is diagnosis-contingent. Accepted categories (requiring further regulatory specification): treatment-resistant MDD (≥4 adequate pharmacotherapy trials + psychological therapy + ECT attempted); schizophrenia spectrum disorders with documented ≥10-year course including clozapine protocol; severe treatment-refractory PTSD. Personality disorders require heightened scrutiny. Existential suffering without a diagnosable neurobiological substrate is categorically excluded.	Kim et al. (2016); Calati et al. (2020); Van Veen et al. (2022); De Hert & Van Assche (2024)
IV Proportionality Review by Judicial Authority	Art. 21 + Art. 14 (K.S. Puttaswamy (2017) 10 SCC 1); parens patriae (judicially restructured);	High Court Division Bench (minimum) conducts proportionality review across three sub-tests: (a) rational connection does suffering arise from the diagnosed	K.S. Puttaswamy v. Union of India (2017); Mortier v. Belgium (2022); Scopetti et al. (2023); Trachsel & Jox (2022)

	Common Cause Medical Board model (restructured with psychiatric expertise)	disorder rather than external/social circumstance? (b) minimal impairment have all less-drastic alternatives, including experimental protocols and palliative psychiatry, been genuinely exhausted given accessible infrastructure? (c) proportionality stricto sensu is death proportionate to the degree and nature of documented suffering? The court must give reasons. Deference to divided clinical opinion is constitutionally impermissible.	

B. Pillar I Neurobiological Substantiation: Giving the Invisible a Legal Shape

The foundational epistemic problem of psychiatric euthanasia is that the suffering it presents does not show on an MRI. Courts that authorise death on the basis of a patient's subjective account of irremediable suffering however compelling, however consistent have not distinguished legally cognisable medical suffering from non-justiciable existential distress. The purpose of neurobiological substantiation is not to demand certainty that no psychiatric patient can provide; it is to anchor the claim of irremediability in demonstrable pathology rather than phenomenological narrative alone. [64]

Contemporary neuroscience has identified consistent structural and functional alterations in patients with severe, treatment-resistant psychiatric disorders: reduced grey matter volume in the prefrontal cortex and hippocampus in treatment-resistant depression; default mode network hyperconnectivity in major depressive disorder; reward system dysfunction in schizophrenia spectrum conditions; and amygdala hypersensitivity in severe PTSD. [65] These findings are group-level correlations they do not establish individual irremediability. The critical legal point: neurobiological findings should be treated as *corroborative substantiation,* not as *independent proof.* They shift the evidentiary burden a patient who presents both a clinical history of documented treatment exhaustion *and* neurobiological findings consistent with that history has made a prima facie case that the State must rebut. A patient who presents only the clinical history, without neurobiological corroboration, has not yet crossed the legal threshold.

The treatment exhaustion documentation requirement serves an equally critical function in the Indian context: it screens out euthanasia requests arising from inadequate access to treatment rather than genuine therapeutic failure. A patient who has received three trials of generic SSRIs in a district hospital and nothing further has not exhausted available treatment they have been failed by a system with 0.75 psychiatrists per 100,000 population. [66] The framework requires

[64]De Hert & Van Assche, supra note 5; Grassi et al., supra note 9 (both emphasising that neurobiological corroboration serves an evidentiary anchoring function, not a categorical exclusion function, in psychiatric euthanasia assessment).

[65]Léa Guérinet & Marie Tournier, Euthanasia and Assisted Suicide for Psychiatric Disorder, L'Encéphale (2021), https://doi.org/10.1016/j.encep.2020.10.002.

[66]Garg, Kumar & Chandra, supra note 30, at 105.

documentation that inaccessibility of specific treatments was itself assessed and recorded so that a court can distinguish 'this treatment did not work' from 'this treatment was never accessible.' The latter supports not euthanasia but a constitutional claim against the State for infrastructure failure.

C. Pillar II Longitudinal Decisional Capacity Assessment: Catching the Fluctuation

The structural inadequacy of point-in-time capacity assessment in the psychiatric context is the most extensively documented failure in the comparative literature. [67] The Appelbaum-Grisso four-component model understanding the nature and consequences of the decision, appreciating the relevance of the information to one's own situation, reasoning about available options, and expressing a consistent choice [68] is a sound evidentiary template, but it was designed for a clinical moment. In psychiatric illness, the four components may be intact during a window of relative stability and profoundly compromised during an acute episode. The longitudinal three-point assessment model proposed here at months 0, 3, and 6 is designed to catch this fluctuation rather than paper over it. It converts a snapshot into a trajectory. And trajectory, for an irreversible decision, is the appropriate evidentiary unit. [69]

The framework also addresses a subtler problem: the treating psychiatrist's capacity assessment is structurally compromised by therapeutic attachment and potentially by their own view on whether euthanasia is the appropriate outcome. An independent assessor has no therapeutic relationship with the patient and no prior commitment to a treatment philosophy. The independence requirement is not a procedural formality it is a structural safeguard against the epistemological contamination that produces unreliable capacity findings.

The Voluntariness Sub-Inquiry. Longitudinal capacity assessment must include a distinct sub-inquiry on voluntariness: whether the request arises from the patient's autonomous preference or from external pressures family burden, financial constraint, social isolation, inadequate care that silently coerce a choice that would not otherwise be made. In India's collectivist social context, this is not a theoretical nicety it is a structural necessity. [70] The framework requires that the capacity assessment panel specifically address and document the voluntariness finding, including the patient's financial circumstances, family dynamics, and access to social support structures.

D. Pillar III Disorder-Specific Eligibility: Refusing the Generic

The single most consequential flaw in the Belgian and Dutch frameworks as applied to psychiatric cases is their generic structure: 'unbearable suffering without prospect of improvement' applies identically to a patient with treatment-resistant depression and to a patient with a dissociative disorder, a personality disorder, or an existential crisis that has been labelled psychiatric without adequate diagnostic rigour. Disorder-specific eligibility is this framework's answer to criterion-drift. It demands that the legal standard specify, for each

[67] Verhofstadt et al., supra note 38; De Hert & Van Assche, supra note 5; Bosma et al., supra note 33 (collectively documenting the structural inadequacy of point-in-time capacity assessment in psychiatric euthanasia practice across Belgian and Dutch contexts).

[68] Appelbaum & Grisso, supra note 27, at 1635–36 (defining the four components as: understanding the nature and consequences of the proposed treatment decision; appreciating its relevance to one's own situation; reasoning about available options; and expressing a consistent choice).

[69] S.H. Van Veen et al., Physician Assisted Death for Psychiatric Suffering: Experiences in the Netherlands, 13 Frontiers Psychiatry (2022), https://doi.org/10.3389/fpsyt.2022.895387.

[70] Paul et al., supra note 21, at 2249–50 (documenting family-mediated and social-contextual pressures on end-of-life decision-making in the Indian psychiatric context); Scopetti et al., supra note 8 (identifying voluntariness verification as an insufficiently developed dimension of existing psychiatric euthanasia frameworks).

eligible diagnostic category, the minimum documented treatment history that must be exhausted before irremediability can be asserted. [71]

The framework identifies, as a preliminary list requiring further regulatory specification: treatment-resistant major depressive disorder with documented exhaustion of a minimum of four adequate pharmacotherapy trials (defined by adequate dose, adequate duration, and documentation), structured psychotherapy, and ECT or rTMS where clinically indicated and accessible; schizophrenia spectrum disorders with a documented minimum ten-year treatment history including an adequate clozapine trial; and severe, chronic PTSD where evidence-based first and second-line treatments have been documentably exhausted. Personality disorders are placed in a heightened scrutiny category not because the suffering they produce is not real, but because their diagnostic instability and known fluctuation of capacity require additional procedural safeguards before irremediability can be treated as established. [72]

Existential suffering however severe, however persistent is categorically excluded in the absence of a diagnosable, neurobiologically substantiated psychiatric disorder. [73] The law's function is not to relieve all suffering; it is to provide a principled basis for distinguishing the category of suffering that justifies an irreversible act from the category of suffering that demands a different response therapeutic, social, or palliative.

E. Pillar IV Proportionality Review: The Court Must Not Become a Rubber Stamp

The Supreme Court's articulation of proportionality as a constitutional norm in *K.S. Puttaswamy v. Union of India*[74] established that any state action affecting fundamental rights must satisfy four prongs: existence of a law, legitimate state aim, proportionality between means and aim, and procedural guarantees against arbitrariness. Transposed to euthanasia adjudication, this standard applies to the court's authorisation decision itself: the court acts in the name of the state when it authorises an irreversible act that terminates a citizen's life, and it must demonstrate through a reasoned order that the authorisation satisfies each prong.

Rational Connection: Does the applicant's suffering arise from the diagnosed disorder, rather than from external or social circumstances that could be addressed by means other than death? A patient whose suffering is primarily attributable to inadequate care, poverty, family abandonment, or social isolation has a claim against the State for infrastructure failure not a claim for euthanasia.

Minimal Impairment: Have all alternatives including experimental protocols, palliative psychiatry, and community-based support restructuring been genuinely and documentably exhausted, given what was accessible to this patient in India's healthcare infrastructure? The framework explicitly does not demand the impossible: a patient with no access to ketamine infusion therapy in a rural district need not be denied eligibility because ketamine was never tried. But it requires that inaccessibility of treatments be documented and that the court be satisfied that inaccessibility was not itself remediable by means other than death.

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[71]Vandenberghe, supra note 37, at S65–S66 (documenting twenty-three years of documented criterion-drift in Belgian psychiatric euthanasia practice as a consequence of generic rather than diagnosis-specific eligibility criteria); De Hert & Van Assche, supra note 5.

[72]Kim et al., supra note 7, at 364 (finding that personality disorders constituted approximately 20% of Dutch psychiatric euthanasia cases, raising particular concern about diagnostic instability); Van Veen et al., supra note 69, at 4–5; De Hert & Van Assche, supra note 5 (recommending heightened procedural scrutiny for personality disorder diagnoses in euthanasia assessment).

[73]Trachsel & Jox, supra note 54, at 521–22 (arguing for a principled legal distinction between clinical psychiatric suffering and non-justiciable existential distress); Scopetti et al., supra note 8 (same).

[74]K.S. Puttaswamy v. Union of India, (2017) 10 SCC 1, ¶¶ 180–85 (India) (Chandrachud, J., concurring) (articulating proportionality as a constitutional norm under Articles 14 and 21).

Proportionality stricto sensu: Is death a proportionate response to the documented degree and nature of the suffering? A court that says 'we accept the expert panel's assessment and therefore authorise' has not applied proportionality review it has delegated it. A court that says 'based on the documented treatment history, neurobiological findings, three independent capacity assessments, the voluntariness inquiry, and our evaluation of the adequacy of available alternatives, we find that the suffering is of a kind and degree that makes continued biological existence constitutionally indignified' has applied it. [75]

VI. PROCEDURAL SCAFFOLD: HOW THE FRAMEWORK OPERATES IN PRACTICE

A. The Nine-Stage Process

The four pillars are substantive standards. The procedural scaffold below translates them into a sequence of institutional actions, each with a designated actor, a defined output, and a legal anchor. The scaffold is designed for operation within India's existing judicial infrastructure it does not require a new tribunal or court; it requires a restructured use of the High Court's existing supervisory and original jurisdiction, supplemented by the Medical Board model from Common Cause redesigned with mandatory psychiatric expertise.

Table 6: Procedural Scaffold Nine-Stage Model for Judicial Authorisation of Psychiatric Euthanasia in India

Stage	Actor / Forum	Action Required	Legal Anchor
1 Trigger	Patient / guardian (if capacity intermittent)	Written application to High Court; supported by treating psychiatrist's preliminary report; translation assistance mandated for non-English speakers	Art. 21; MHA S. 3; right of access to courts
2 Panel Appointment	High Court Registrar	Court appoints panel of three independent psychiatrists (at least one from NIMHANS or equivalent centre of excellence; none treating the applicant)	Common Cause Medical Board model; MHA S. 23 (composition adapted)
3 Neurobiological Report	Psychiatric Panel	Generates: (a) diagnostic confirmation; (b) treatment exhaustion documentation; (c) neuroimaging interpretation; (d) preliminary capacity assessment. Delivered to court in ≤60 days.	Pillar I; De Hert & Van Assche (2024) two-track model
4 Longitudinal Capacity Assessment	Two independent psychiatrists	Three capacity assessments at months 0, 3, and 6; Appelbaum-Grisso structured template; findings disclosed to court and applicant; disagreements recorded in full	Pillar II; Appelbaum & Grisso (1988)

[75] Scopetti et al., supra note 8.

5 Amicus Curiae (Psychiatric Expert)	High Court	Court appoints amicus with no prior contact with applicant; reviews Panel Report; cross-examines Panel members before court; submits independent opinion on neurobiological substantiation and capacity reliability	Adversarial evidentiary principle; Common Cause judicial oversight model
6 Proportionality Hearing	High Court Division Bench	Open hearing (subject to in camera application); State represented by Government Pleader; applicant represented (legal aid if required); court applies three-pronged proportionality test; deference to divided clinical opinion not permitted	K.S. Puttaswamy (2017); Pillar IV
7 Waiting Period + Renewal	High Court / Psychiatric Panel	Minimum 6-month waiting period from first capacity assessment to order; applicant may withdraw at any stage; capacity re-assessed at month 5 to ensure continuity of consent	Belgian one-month minimum (adapted upward for psychiatric context); MHA S. 5 advance directive model
8 Authorisation Order + Record	High Court Division Bench + JMFC	Written order with reasons; mandatory full copy recorded with JMFC (not mere intimation); National Registry of Psychiatric Euthanasia Orders maintained by Ministry of Health	Common Cause JMFC intimation (upgraded to full record); Art. 21 (reasoned order as constitutional minimum)
9 Post-Authorisation Review	National Psychiatric Euthanasia Review Committee (legislation required)	All authorised cases reviewed within 12 months; annual public report; findings reported to Parliament; research dissemination to inform criterion evolution	Belgian FCECE model (restructured as prospective); Canadian MAiD reporting mechanism

B. The Equity of Access Principle

The procedural scaffold must be read alongside what this paper calls the Equity of Access Principle: the evidentiary standard for treatment exhaustion must be calibrated to what was actually accessible to the specific patient in their actual healthcare environment not to what would be available to a patient in a well-resourced urban tertiary hospital. A patient in rural Karnataka who has received four years of generic pharmacotherapy in a district hospital, without access to structured psychotherapy or neuromodulation, and who meets the neurobiological substantiation threshold, has exhausted available treatment in a legally meaningful sense even if additional treatments theoretically exist somewhere in India.

This principle guards against two simultaneous errors: treating infrastructure-limited patients as ineligible because they were never given the treatments they needed (punishing them for the State's failure), and treating infrastructure as irrelevant and accepting inadequately treated patients as irremediable (laundering the State's failure into a licence to kill). The court must ask explicitly: was this patient's treatment failure a failure of the treatment, or a failure of the State to provide it? Only the former constitutes evidence of irremediability. The latter constitutes evidence of a separately actionable constitutional violation. [76]

C. Cultural Safeguards: The Collectivist Coercion Problem

India's social architecture is predominantly collectivist. Family pressure, resource constraints, social shame associated with psychiatric illness, and the absence of community support structures all create conditions under which a patient's expressed wish to die may be less an autonomous preference than a response to a social environment that has made continued living feel impossible. The voluntariness sub-inquiry under Pillar II is this framework's primary cultural safeguard. But it must be supplemented: the capacity assessment panel must include at least one social worker or community psychiatry specialist trained in identifying coercive family dynamics, financially distress-driven decision-making, and culturally specific expressions of passive suicidality that may be misread as autonomous end-of-life preferences. In India's collectivist context, the framework must actively screen *against* family influence rather than merely noting its presence. [77]

CONCLUSION AND LIMITATIONS

The starting point of this paper was a foundational paradox: courts asked to adjudicate psychiatric euthanasia claims are confronted with a demand for objectivity from a domain that medicine itself has not yet fully objectified. The response to this paradox, across every jurisdiction examined, has been to extend somatic evidentiary frameworks to psychiatric claims without redesigning their underlying logic and to permit judicial deference to clinical opinion to fill the gaps that legal standards should have covered. The Netherlands produces retrospective rubber stamps. Belgium produces documented criterion-drift after twenty-three years. Canada produces intelligent legislative paralysis. India produces a constitutional entitlement without a procedural corridor.

Against this backdrop, the paper has argued for a specific institutional response: a four-pillar neuro-legal framework that equips courts with structured evidentiary standards for psychiatric euthanasia adjudication, grounded in Indian constitutional law and calibrated to Indian institutional reality. The framework does not resolve the bioethical debate about whether psychiatric euthanasia should be permitted. It resolves a narrower and more urgent legal question: if a court is ever asked to adjudicate a psychiatric euthanasia claim which, given India's 14,305 annual mental illness–linked suicides [78] and evolving Article 21 jurisprudence, is not a remote hypothetical what standards should it apply?

The four pillars neurobiological substantiation, longitudinal decisional capacity assessment, disorder-specific eligibility criteria, and proportionality review collectively produce a framework that is constitutionally defensible, institutionally operable, and empirically

[76] Common Cause, supra note 2, ¶¶ 166–172 (Chandrachud, J., concurring) (recognising the State's positive constitutional obligation under Article 21 to ensure dignified conditions of life, which by extension encompasses adequate healthcare provision); Gopalan & A.G., supra note 55 (discussing the interface between healthcare infrastructure gaps and end-of-life jurisprudence in India).

[77] Paul et al., supra note 21, at 2249–51; Navandar, supra note 20 (both identifying collectivist family dynamics and psychiatric stigma as structural coercion risks specific to the Indian context that any euthanasia framework must actively screen against).

[78] NCRB 2024, supra note 1.

grounded. Neurobiological substantiation converts the claim of irremediability from phenomenological assertion to evidentially anchored argument. Longitudinal capacity assessment converts the point-in-time clinical snapshot into a legally adequate trajectory. Disorder-specific eligibility converts generic 'unbearable suffering' into a structured diagnostic and treatment-history inquiry. And proportionality review converts judicial deference into judicial reasoning which is, ultimately, the only constitutionally legitimate form of adjudication.

B. Limitations

1. Empirical Limitation. The framework requires neurobiological substantiation in a domain where the science is probabilistic rather than determinative. There are, as of today, no universally validated biomarkers for treatment-resistant depression, schizophrenia, or severe PTSD that permit reliable individual-level irremediability determination. The framework's requirement that neuroimaging findings be 'consistent with' the clinical diagnosis is deliberately calibrated to this limitation but courts will need continuing judicial education and expert guidance to draw reliably the line between corroboration and rubber-stamp of clinical assertion.

2. Infrastructure Limitation. The nine-stage procedural scaffold assumes the availability of independent psychiatric experts, neuroimaging facilities of adequate diagnostic quality, and a National Psychiatric Euthanasia Review Committee with resources to conduct prospective review. India currently has 0.75 psychiatrists per 100,000 population [79] and approximately 47 government-run mental hospitals for a population of 1.4 billion. Any legislative or judicial adoption of this framework must be preceded by or at minimum contemporaneous with meaningful investment in the psychiatric workforce and neuroimaging infrastructure that the framework's standards presuppose.

3. Doctrinal Limitation. The single most consequential structural gap the absence of a physician exception to BNS S. 108 / IPC S. 306 cannot be cured by judicial interpretation alone. Legislative amendment is constitutionally required, and any attempt to achieve this outcome through judicial creativity rather than parliamentary action would produce precisely the kind of legal uncertainty that the framework is designed to eliminate.

4. Cultural Limitation. Indian clinicians report significant uncertainty and discomfort about both the clinical and ethical dimensions of euthanasia evaluation. [80] The National Mental Health Survey found a 70–92% treatment gap, [81] meaning the majority of persons with mental disorders in India have never had adequate access to care, let alone to informed discourse about end-of-life options. A framework, however structurally sound, deployed in the absence of public education, clinical training, and patient community consultation risks generating outcomes that serve neither the patient's actual wishes nor the society's values. The framework must be understood as the conclusion of a process not its beginning.

C. Open Research Questions

First: How can decisional capacity be reliably assessed in Indian patients requesting psychiatric euthanasia, given the shortage of trained independent evaluators, linguistic diversity, and the absence of culturally validated capacity instruments in Indian languages? The Appelbaum-Grisso model was developed for English-language, Western cultural contexts its application to a patient assessed in Kannada or Tamil requires empirical validation that does not yet exist.

Second: What culturally sensitive guidelines can balance individual autonomy with protection against coercion in India's collectivist social context, where family pressure, resource

[79]Garg, Kumar & Chandra, supra note 30, at 105.

[80]Paul et al., supra note 21, at 2251 (finding that Indian psychiatrists report significant ethical and clinical discomfort regarding euthanasia evaluation); Chavan & Patra, supra note 22; Gupta & Bansal, supra note 23.

[81]NMHS 2016, supra note 29, at 88.

constraints, and psychiatric stigma may silently distort patient preferences in ways invisible to a framework developed for Western individualist assumptions?
Third: How can the infrastructure gap in palliative and psychiatric care be addressed so that euthanasia requests arising from inadequate care rather than genuinely refractory suffering can be reliably identified and redirected? The Equity of Access Principle proposed in this paper is a conceptual answer; its operationalisation requires empirical research into the minimum treatment standard constituting genuine exhaustion of available options across India's specific regional healthcare contexts.

This paper is addressed to the judge who will one day sit with a psychiatric euthanasia petition before them and no framework to apply. It is addressed to the legislature that will eventually be asked to fill the gap that Common Cause left open. And it is addressed to the patient whose name this paper does not know, whose suffering it cannot quantify, and whose dignity it has attempted in the only way law can to take seriously. The law's job is not to make death easy. Its job is to make sure that when death is chosen, it is chosen by the right person, for the right reasons, with the right evidence, under the right supervision. The neuro-legal framework proposed here is this paper's attempt to define what 'right' means not perfectly, not finally, but rigorously enough to be the beginning of a principled answer.

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