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RIGHT TO DIE WITH DIGNITY

EXPLORING THE LEGAL POSITION OF EUTHANASIA IN INDIA

-Shambhavi Pushkar Gokhale

INTRODUCTION:

“Can you keep yourself in a closed box for sixty seconds.... just sixty seconds?”

When Ethan Mascarenhas from the 2010 film *Guzaarish* challenges the judge to endure just one minute inside a sealed box, he forces us to try and imagine the claustrophobia of being trapped in one's own body. His request for euthanasia is not conceived out of psychological defeat but rather from the assertion of his bodily autonomy and rights. He does not negate his right to live rather wishes to assert his right to thrive and grow as a living person. While constitutional frameworks explicitly guarantee citizens the right to live, does that right inherently encompass the corresponding right to die?

Classical and modern philosophy have a dialectic perspective when it comes to euthanasia. While Socrates would have prioritised the quality of life over life itself, Kant would have strictly opposed the same and prioritised the preservation of life as long as rationality exists in the individual. Utilitarianism would have considered it as the minimisation of suffering and maximisation of happiness whereas Aristotle would have focused on the intention and moral character of the individuals involved in order to determine the morality of the act. Consequently, the concept of euthanasia cannot be viewed as an isolated clinical act, but rather through a multidimensional lens that weaves together profound ethical, moral, religious, political, and social implications.

The word “euthanasia” comes from the Latin roots “eu” means good and “thanatos” means death translating to the term “good death”. In modern times the term has been classified into

five main categories depending on characteristics like involvement of another individual in the act and competency and state of the patient, these categories include;

a) Passive and Active Euthanasia :

Passive euthanasia involves the withdrawal of life sustaining treatments in order to allow natural death of the patient whereas active euthanasia involves the administration of a lethal agent by another person into the patient in order to relieve intolerable pain or suffering.

b) Voluntary, Non voluntary and Involuntary Euthanasia:

If the patient is competent to give consent to the above procedures it is called as a voluntary euthanasia and if a guardian or next of kin provides consent in the absence of a competent patient, it is called as non-voluntary euthanasia. Involuntary euthanasia is generally considered to be illegal as no prior consent of the patient or his guardian is taken before performing the act.

In *Debating Euthanasia* (2011),¹ Emily Jackson argues for legalization of euthanasia and advocates it as an exercise of bodily autonomy and liberty. She views euthanasia as an act of compassion and postulates that giving terminally ill patients the option to painlessly end their life would help reduce their anxiety and fears in regards to eventual death. It would provide them the autonomy to choose their time and method of death and thus give them some kind of control over their condition, something which patients often desire. Conversely, John Keown states that presenting euthanasia as a viable option would indirectly pressure the competent but vulnerable patients to seek an earlier death in order to relieve financial or psychological burdens on their families. Rebutting Jackson's view on autonomy, he states that every exercise of autonomy cannot necessarily be termed moral and intentional killing is violative of foundational legal and moral norms. Keown asserts that the proper response to such circumstances is to improve palliative care and pain relief mechanisms for the patients. Opponents of euthanasia often state that the major reason for opposition to the concept stems from the inherent doubts of competency of the patient in giving consent. They propose that a person suffering intolerable pain cannot reasonably be expected to be rational as the intense pain shadows cognitive abilities of the individual, Thus they state that we can never have sufficient evidence to believe that such patients are competent and have the capacity to consent. Expanding on this tension, Michael Cholbi postulated that while legalization of euthanasia

¹ William E May , *Debating Euthanasia* by Emily Jackson and John Keown, National Catholic Bioethics Quarterly 2012

faces vehement opposition, the absence of clear statute on the same leads to illegal attempts of assisted suicides and euthanasia which are far more dangerous for the society. He emphasizes that palliative care, particularly for individuals requiring assisted living—neither heals the patient nor exacerbates their underlying condition, effectively confining them to a state of medical stagnation. Furthermore, He challenges the moral asymmetry often drawn between active and passive euthanasia and contends that deeming passive euthanasia moral under the guise of allowing a 'natural death' through the withdrawal of treatment while condemning² active euthanasia as immoral due to direct medical intervention creates a false distinction. As both acts share the identical outcome of accelerating death to relieve suffering.

Robert Young in his article “Voluntary Euthanasia” specifies five standard criteria’s taken into consideration when ascertaining candidacy for euthanasia. These include that;

1. The patient must be suffering from a terminal illness
2. The patient is unlikely to benefit from the discovery of a cure for that illness during his lifetime
3. The patient is suffering intolerable pain as a direct consequence of the disease
4. The patient expresses an enduring, voluntary, competent wish to die or expresses so before the loss of his competency to do so
5. The patient is unable to end life without assistance

However it is pertinent to note that these conditions reveal significant blind spots. By excluding patients who are quadriplegic or suffer from chronic mental and physical diseases, it does not take into account mental torment and suffering which may be an indirect consequence of the nature of disease to be a condition for eligibility. Furthermore, the fifth condition inherently limits the exercise of voluntary euthanasia to those who are unable to end life without assistance but does not consider those who are capable of ending their own lives fit to be a candidate, thus excluding patients suffering from terminal cancer, psychiatric conditions etc.³

LEGITIMATISATION OF EUTHANASIA IN THE WORLD AND ITS IMPACT:

Several countries like the United States of America through Karen Ann Quilen Case 1976 and United Kingdom through the Airedale NHS Trust vs Bland 1993 case had sanctioned the use

² Cholbi Michael, Freedom over death, Aeon Essays

³ Young Robert , Voluntary Euthanasia ,Stanford Encyclopaedia for Philosophy, Edward N Zalta and UN Nodelman

of passive euthanasia. Switzerland had decriminalized assisted suicide through Article 115 of the Swiss Criminal Code as far back as 1942 though it stopped short of authorizing active medical intervention. The global paradigm shifted in 2002 when Netherlands became the first country to legalise active euthanasia and physician assisted suicide and codify provisions in regards to passive euthanasia through the Termination of Life on Request and Assisted Suicide (Review Procedures) Act in 2001 (which came into force in April 2002). Following the Netherlands' landmark legislation in 2002, a growing number of jurisdictions codified active euthanasia into law, beginning with Belgium later that year, followed by Luxembourg (2009), Colombia (2015), Canada (2016), Spain (2021), New Zealand (2021), Portugal (2023), and most recently, Ecuador (2024).

However, this rapid expansion of global legitimacy has intensified debates regarding regulation and oversight. Empirical scrutiny of the Dutch model began early with the landmark Remmelink Report (1991), the first comprehensive official government commissioned study made to evaluate pre-statutory practices. The report chaired by Professor Jan Remmelink, the then Attorney General of the Dutch Supreme Court disclosed shocking statistics in regards to the number and method of deaths occurring by physician assistance. The statistics disclosed that;

1. 2300 deaths occurred in that year due to the use of active euthanasia and this constituted 1.8% of the total deaths of that year.
2. 400 deaths occurred through the use of physician assisted suicide accounting 0.2% of the total deaths of that year
3. 1040 deaths occurred through non voluntary active euthanasia where physicians had administered life ending medications without any simultaneous explicit consent of the individuals. This happened mostly in cases where the patient was considered incompetent to consent however it is pertinent to note that the real number of competent and incompetent patients here is debatable.
4. The report also noted that total explicit requests made by the patients was around 9000 out of which only close to one third were granted.
5. There were several cases where physicians had administered high dosage pain management medications with the partial intent or expectation to hasten the death of the patient.

Far from creating a new medical reality the data suggested that end-of-life interventions were already taking place without oversight. Codification offered the state a mechanism to pull these practices out of the legal shadow and subject them to statutory review. Yet, as the Netherlands continues to publish yearly empirical updates recent data from 2024–2025 has reignited global scepticism, raising fundamental questions about the long-term societal consequences of broad legalisation. The Regional Euthanasia Review Committees have reported a 8.8% rise in the number of deaths by euthanasia than the previous year 2024. The data suggests that most common conditions for opting euthanasia included cancer, nervous system disorders, cardiovascular diseases and mental health issues. The reports have also disclosed a rise in cases of psychiatric euthanasia with over 2 cases in 2021 to 138 cases in 2023 to 219 cases in 2024 and 174 cases in 2025 of the same. A new category of euthanasia has also been seen known as duo euthanasia where partners, siblings and relatives opt for dying together, there are over 60 cases of the same as per 2024 statistics. This increase in the cases of euthanasia, especially that of psychiatric euthanasia have caused concerns amongst the global community as unlike physical ailments the incurability, intensity of suffering and competency of individuals with mental and psychiatric ailments is extremely difficult to analyse⁴. Opponents advocate that this rise in psychiatric euthanasia in Netherlands represents a slippery slope where what served as a rare exception for a minority of population is gradually normalized for a broader demographic. They state that patients who are struggling and suffering are more likely to end there suffering than try their level best to cure it, if the option of euthanasia is easily available, this applies especially in cases psychiatric illnesses where there is no explicit exhaustive criteria of eligibility except that of intolerable suffering without prospect of improvement. The statistics of Netherlands tells us that although the legitimization of euthanasia provides greater exercise of liberty and autonomy to the patients, there is also a possibility of the concept becoming normalized or routinized instead of finding or discovering other better alternatives.

LEGAL POSITION OF EUTHANASIA IN INDIA:

When we consider the position of euthanasia in India, it is very important to understand the socio-religious landscape which shapes the perspective on bodily autonomy, suffering and rights. Across India's diverse religious traditions, there exists a shared consensus against active intervention in the process of death but is balanced by the varying degrees of acceptance for allowing death to occur naturally. Within Hinduism life is viewed as precious and thus any kind

⁴ Jim Van OS, MD, PhD, Wilbert Van Raaij MD, Mark S Konrad MD,DFAPA, Psychiatric euthanasia in Netherlands : Young People, Procedural Medicine and Limits of Psychiatry

of active intervention to accelerate death of an individual is rejected, as it is considered as the disruption of the karmic cycle and the cosmic destiny of the individual. Voluntary departure is permissible only if a person is of old age and has fulfilled all his worldly responsibilities. Conversely, Christianity and Islam strictly condemns any form of euthanasia as they believe death to be an action of God and any artificial acceleration of the same is impermissible⁵. On the other hand, Jainism makes a sharp distinction between suicide and voluntary death, permitting the latter only if it is accompanied by a spiritual intention and peace and not as an escape from worldly despair. These diverse perspectives are reflected in India's legal perspective as well. The Indian Courts have taken a cautious stance when it comes to the practice of euthanasia. While passive euthanasia has been legalized, active euthanasia remains to be criminalized under Bhartiya Nyaya Sanhita 2023 under Section 100 and Section 101. The journey of navigating this delicate boundary between life, death, and criminal liability has been defined by a series of landmark legal battles. These were as follows;

(a) Gian Kaur vs The State of Punjab (1996)⁶

The Supreme Court pronounced that the right to live under Article 21 does not inherently contain the corresponding right to die as death being the extinction or negation of life cannot logically follow from the former. The judgement also distinguished the concept of right to die from the concept of right to die with dignity emphasizing that the former enunciates an unnatural, premature termination of life whereas the latter allows the peaceful termination of a terminally ill suffering individual by withdrawal of artificial life prolonging support. It also stated that while active intervention was firmly rejected, passive euthanasia would not amount to criminal liability if the patient were living in a permanent vegetative state. This judgement formed the basis of the 2011 Aruna Shanbaug case which interpreted the application of passive euthanasia.

(b) Aruna Shanbaug vs Union of India (2011) ⁷

Moving one step ahead of the previous judgement, the Supreme Court asserted the doctrine of Parrens Patriae, stating that in cases of PVS patients who cannot assert their competent consent, the High Court would act as the deciding authority. It also emphasized on some court mandated protocols to be followed when it came to passive euthanasia of such patients in order to prevent

⁵ Euthanasia, assisted dying, suicide and medical ethics, BBC 2012

⁶ Gian Kaur v. State of Punjab, (1996) 2 S.C.C. 648.

⁷ Aruna Ramchandra Shanbaug v. Union of India, (2011) 4 S.C.C. 454

potential abuse by relatives and physicians. The judgement became monumental to form the foundation of the concept of Advanced Directive and Living Wills postulated in the 2018 Common Cause case.

(c) Common Cause vs Union of India (2018) ⁸

The Supreme Court held that right to live with dignity includes the right to die with dignity and forcing artificially prolonged medical life is inhumane in nature. It officially legalized passive euthanasia and went one step further from its previous judgements. The judgement also provided conditions and guidelines on the concept of living wills and advanced directive, putting stringent regulations and criteria's on the physicians, relatives and medical board for the same. The process of authorisation of an advanced directive includes careful scrutiny of the patient and the will by the courts, government authorities and medical boards. This judgement helped in providing clarity in regards to concepts affiliated with passive euthanasia.

(d) Harish Rana vs Union of India (2026) ⁹

This was the first successfully conducted instance of court approved passive euthanasia. The Supreme Court interpreted the use of Clinically Assisted Nutrition and Hydration treatment through Percutaneous Endoscopic Gastronomy tube as a form of treatment and not primary care and allowed the withdrawal of the same through medical intervention. The court clarified that such withdrawal of treatment must be done under lawful medical supervision and only when recovery is completely impossible.

CONCLUSION

India's end of life jurisprudence provides a nuanced perspective of caution. In a world where exceptions can be normalized with accessibility, it is of utmost importance that we anchor our law on fundamental morals and principles and create a clear demarcation between the fine line of necessity and desire.

With the advent of modern medicine and technology, the difference between prolonging life and extending the natural process of death becomes increasingly ambiguous. The world today

⁸Common Cause (A Regd. Soc'y) v. Union of India, (2018) 5 S.C.C. 1 and MANU/SC/0232/2018 Common Cause vs Union of India

⁹ Aruna Ramchandra Shanbaug v. Union of India, (2011) 4 S.C.C. 454

Reference used for Indian perspective : Sinha VK, Basu S, Euthanasia Indian perspective, Indian Journal for Psychiatry, 2012 April 54(2)

faces a profound question ; Can we as a society preserve the sanctity of life when the rights of those in consideration lie on the other side of the balance ?