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Active And Passive Euthanasia: Constitutional, Ethical And Comparative Perspectives With Case Law

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Abstract

This paper examines the legal and constitutional contours of active and passive euthanasia in India, situating recent jurisprudence within a broader comparative and ethical framework. Building on landmark decisions from Gian Kaur v. State of Punjab to Aruna Ramachandra Shanbaug v. Union of India and Common Cause (A Regd. Society) v. Union of India, it argues that the Supreme Court has crafted a cautious but significant right to die with dignity under Article 21, confined to passive euthanasia and advance directives while continuing to prohibit active euthanasia. The central research claim is that this judge-made regime, though normatively grounded in autonomy and dignity, remains fragile in the absence of comprehensive legislation, institutional capacity and palliative-care infrastructure.

Methodologically, the paper employs doctrinal analysis of Indian case law and statutory provisions, reads them alongside the Law Commission's 241st Report and palliative-care policy documents, and engages in comparative study of euthanasia laws in the Netherlands, Belgium and other jurisdictions. It identifies key gaps: low awareness and complex procedures around passive euthanasia, uneven implementation of advance directives, and limited empirical engagement with how socio-economic inequalities shape end-of-life choices. The comparative analysis shows that more permissive regimes are embedded in robust statutory, reporting and review structures that India currently lacks.

The paper concludes with a sequenced reform agenda: codifying the passive-euthanasia framework through an End-of-Life statute, strengthening palliative care and ethics infrastructure, simplifying advance-directive procedures, and only then considering, through

democratic deliberation, whether a tightly circumscribed physician-assisted dying regime is institutionally and ethically feasible for India.

Keywords: Active euthanasia; passive euthanasia; right to die with dignity; Article 21; Indian Constitution; advance directives; palliative care; Law Commission of India; comparative euthanasia law

I. Introduction

Euthanasia is a debate that has its own special place where the boundaries of law, ethics, medicine, religion, and human rights converge. It is a debate that centers on a central issue: whether a person has a right to choose to end his or her life or opt out of life-prolonging treatment without facing criminal sanctions or imposing them on those who assist him or her in the process. It is in this debate that a key difference is made between passive and active euthanasia. It is the difference between intervening in a person's life and causing death and refraining from treatment in such a manner that the body is left free to die a natural death. The difference has been treated differently in various jurisdictions. Passive euthanasia is often seen as more acceptable than active euthanasia.

In the context of India, this debate has assumed a particular constitutional dimension. The early cases of "right to die" in India, such as P. Rathinam v. Union of India and Gian Kaur v. State of Punjab, posed the question of whether a right to die would fall within the scope of Article 21 of the Constitution of India. The later cases of Aruna Ramachandra Shanbaug v. Union of India and Common Cause (A Regd. Society) v. Union of India have shifted the focus from a general right to die to a particular right to die with dignity and to refuse any prolonging treatment. The jurisdictions of the Netherlands and Belgium, which have enacted statutory provisions to allow euthanasia, provide an important area of comparison. The present paper aims to explore the conceptualization of active and passive euthanasia, the evolution of case law in India, the relevance of comparison, and the ethical and constitutional dimensions of the subject.

II. Conceptual Framework: Defining Euthanasia

The term 'Euthanasia' is generally understood in bioethics as the deliberate action of a physician to end a patient's life to relieve suffering. It is usually distinguished from palliative care, which seeks to alleviate pain and suffering without a wish to end life, even if some of the

treatments may have side effects that result in shortening life. It is also distinguished from 'Physician Assisted Suicide' where the doctor assists the patient but the patient performs the final act, and 'refusal of treatment' where no act is performed to end life. Within 'Euthanasia' itself, the distinction between active and passive is of utmost importance. Active euthanasia is a deliberate and positive act, for example, giving a lethal injection, which is performed for the purpose of causing death. Passive euthanasia, on the other hand, is a decision to stop treatment, thus allowing death to occur from the disease or condition. The Supreme Court of India has clearly adopted this distinction and has held that 'passive euthanasia' is permissible but 'active euthanasia' is prohibited unless legislation is enacted.

III. Euthanasia and the Indian Constitution

A. Early "Right to Die" Jurisprudence

In a notable case of P. Rathinam v. Union of India[1], a two-judge bench of the Supreme Court struck down Section 309 of the Indian Penal Code, which criminalized the attempt to suicide, on the basis that the right to life under Article 21 of the Indian Constitution inherently entailed a right not to live. However, in Gian Kaur v. State of Punjab, a five-judge bench of the Supreme Court overruled the decision of the two-judge bench and reinstated the validity of Sections 306-309 of the IPC, holding that Article 21 of the Indian Constitution does not inherently entitle a person to a right to die. The rationale for this decision was based on the fact that the "right to life" was a right to live with human dignity until the end of life. Such a right conceptually did not allow for a right to end life. Significantly, in Gian Kaur[2], the Supreme Court had also noted that the accelerated death of a person suffering from terminal illness or in a persistent vegetative state may fall within the ambit of a dignified end of life and had to be considered on a case-by-case basis.

B. Aruna Ramachandra Shanbaug v. Union of India (2011)

The case of Aruna Shanbaug[3] became the first occasion for the Supreme Court to directly address euthanasia. Aruna, a nurse at Mumbai's KEM Hospital, was left in a persistent vegetative state for over three decades following a brutal sexual assault and strangulation in

[1] P Rathinam v Union of India (1994) 3 SCC 394.
[2] Gian Kaur v State of Punjab (1996) 2 SCC 648.
[3] Aruna Ramachandra Shanbaug v Union of India (2011) 4 SCC 454.

1973. A public-spirited journalist filed a petition seeking permission for euthanasia, arguing that continued artificial sustenance served no purpose and violated her dignity.

The Court refused to accede to the specific request regarding the withdrawal of the feeding tubes, in large measure because of the opposition of the hospital staff to euthanasia and their continued care of Aruna with evident affection. Nonetheless, the Court undertook a thorough examination of foreign law and concluded that passive euthanasia, or the withdrawal of life support in specific circumstances, could be permissible in India with the permission of the High Court. The Court issued guidelines regarding the withdrawal of life support with the permission of doctors or "next friends," subject to the opinion of a medical board appointed by the High Court and a bench of High Court judges. Active euthanasia involving the injection of lethal drugs was held to be impermissible in the absence of legislation.

C. Common Cause v. Union of India (2018) and Recognition of Advance Directives

In Common Cause (A Regd. Society) v. Union of India[4], the Constitution Bench re-examined the issue in a broader constitutional context. The petitioner claimed a recognition of the right to die with dignity as part of Article 21 and sought a declaration of the legality of passive euthanasia and "living wills." The court unanimously held that "the right to die with dignity is an inseparable part of the right to life as enshrined in Article 21 of the Constitution of India." The court highlighted that "forcing a person to undergo any kind of treatment which is against his wish and desire violates his bodily integrity and autonomy, which has been highlighted in a series of judgments including Justice K.S. Puttaswamy (Privacy)[5]."

The Court affirmed the permissibility of passive euthanasia in India and, crucially, recognised the legal validity of advance directives through which a competent adult can specify in advance that certain life-sustaining treatment should be withheld or withdrawn in defined situations. It issued elaborate guidelines on the form, execution and implementation of such directives, including requirements of witnesses, attestation, and multiple medical boards. At the same time, the bench reiterated that active euthanasia remains impermissible and would require legislative action.

D. Subsequent Modifications and Harish Rana

[4] Common Cause (A Regd Society) v Union of India (2018) 5 SCC 1.
[5] Justice KS Puttaswamy v Union of India (2017) 10 SCC 1.

It was quickly seen that the Common Cause guidelines were overly complex to follow in the real world of hospital practice.In 2023, and again in 2026, the procedure was modified by the Supreme Court, which simplified the advance directive requirements, cutting back on layers of scrutiny but maintaining the basic protections. It also reduced the duplicative aspects of the hospital level medical boards and the district level medical boards, and simplified the magistrates' roles. In March 2026, the modified procedure was utilized in the case of Harish Rana, which was widely reported to be the first case in which passive euthanasia was formally permitted under the Common Cause procedure. The Court authorized withdrawal of life-sustaining treatment in accord with the revised guidelines, reiterating that such treatment is grounded in the Article 21 right to die with dignity, which is not criminal in nature to treating physicians.

VI. Comparative Perspectives

A. Netherlands

The Dutch legislation, the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002, formalized what had developed in case law and prosecution policy.[6] It removes criminal liability from physicians performing euthanasia or assisted suicide, provided they adhere to "due care" criteria. These criteria include, but are not limited to, the following: that the request is voluntary and well-considered, that suffering is unbearable with no prospect of improvement, that the patient is informed about their condition and prospects, and that there is no reasonable alternative. Consultation with at least one independent doctor to examine the patient and provide a written opinion is required, after which the case is referred to a regional review committee.

Empirical studies from the Netherlands have generated an extensive literature discussing compliance, under-reporting, and the extension of euthanasia to psychiatric conditions and dementia.[7] Supporters argue that legalisation promotes transparency, allows for oversight and reduces clandestine practices, while critics worry about expanding indications and subtle social pressure on vulnerable groups.For this paper, the Dutch model illustrates how a legal system can move from a strict prohibition to regulated permission of both active euthanasia and assisted suicide, grounded in autonomy and physician responsibility.

[6] Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 (Netherlands).
[7] John Griffiths, Heleen Weyers and Maurice Adams, Euthanasia and Law in Europe (Hart Publishing 2008).

B. Belgium and Other Jurisdictions

Belgium's Euthanasia Act 2002 followed a similar trajectory but with its own features.[8] The Act defines euthanasia as intentionally terminating life by someone other than the person concerned, at that person's request, and sets conditions including the presence of a serious and incurable disorder, constant and unbearable physical or psychological suffering, and the absence of reasonable alternatives.[43] Initially limited to competent adults and emancipated minors, the Belgian regime was later extended, under strict conditions, to non-emancipated minors experiencing unbearable suffering, triggering sharp ethical debate.

Other countries have a range of rules, including the Canadian federal system's Medical Assistance in Dying, which includes physician-assisted and self-assisted death for adults who satisfy eligibility criteria, some U.S. states have 'Death with Dignity' laws, which allow physician-assisted suicide but not euthanasia, and Colombia and New Zealand have, through court and legislative processes, respectively, sanctioned some form of euthanasia/assisted death. In contrast, the U.K. maintains a blanket ban on euthanasia and assisted suicide, although the courts have sanctioned the withholding of life-sustaining treatment and encouraged the government to rethink the policy. India's policy, permitting only passive euthanasia and subject to judicially designed safeguards, is more similar to the U.K. and the common law jurisdictions, even though it is informed by the latest global norms on the issue of dignity and autonomy.

VII. Ethical and Constitutional Debates

A. Autonomy, Dignity and Sanctity of Life

Autonomy, the respect for the autonomy and dignity of the individual, is a core argument in the case for euthanasia, where the supporters of the practice hold the view that the individual has the right to decide the time and manner in which he would prefer to die, especially in the face of unbearable and incurable suffering. The recognition by the Supreme Court of India in the Common Cause case that the right to die with dignity is part of the fundamental right to life under Article 21 can be viewed as a validation of the autonomy-based argument in the case of passive euthanasia. This is because the court made the link to the right to privacy, as established in the case of Justice K.S. Puttaswamy, where the court held the view that the autonomy and integrity of the body is a fundamental right.

[8] Belgian Act on Euthanasia 2002.

At the same time, the emphasis in the Constitution and in religious beliefs on the sanctity of life must be borne in mind, and the distinction between the right to life and the right to die must not be blurred. This is evident in the Court's emphasis in the Gian Kaur case that life is a gift, and it is the duty of the Constitution and the State to preserve it, not destroy it.[9] Besides, the religious beliefs in India, including Hinduism, Christianity, and Islam, place a lot of emphasis on the spiritual importance of the process of death and express deep disquiet at the practice of intentionally ending life. This is evident in the Court's acceptance of passive euthanasia, which could be seen as permitting the process of death and not interfering with it, and in the rejection of active euthanasia, which would require interference in the process of death.

B. Vulnerability, Inequality and Risk of Abuse

A second set of ethical concerns centres on the risk that legalising euthanasia could expose vulnerable populations—such as the poor, elderly, disabled or socially marginalised—to subtle or overt pressure to "choose" death. In contexts where healthcare is expensive and social security minimal, a patient may feel obligated to relieve their family of financial burden, casting doubt on the voluntariness of requests for euthanasia. Feminist and disability-rights scholars also warn that legal regimes permitting euthanasia may reinforce notions that lives with serious illness or disability are less worth living.

The Indian Supreme Court has attempted to address these concerns through stringent procedural safeguards around passive euthanasia and advance directives, including multiple medical opinions and, initially, judicial oversight. However, the potential for abuse cannot be entirely eliminated, particularly in under-regulated private healthcare settings. Robust palliative care, social support systems, and legal aid are therefore essential complements to any euthanasia framework, so that requests to forego treatment or withdraw life-support arise from informed, uncoerced choices rather than desperation.[10]

Hypothesis

A second set of ethical concerns revolves around the possibility that the legalization of euthanasia may subject certain groups, including the poor, the elderly, the disabled, and the socially marginalized, to subtle or even direct pressure to 'choose' death.[53] In a society where medical care is costly and social security is low, a patient may feel compelled to relieve their

[9] Supra note at 2.
[10] Law Commission of India, Report No 241: Passive Euthanasia (2012).

family of a financial burden, thereby casting a suspicious eye on the voluntary nature of a request for euthanasia.[54] Feminist and disability rights theorists have also pointed out that a legal framework for euthanasia may, in fact, serve to confirm the view that a life lived with illness or disability is not worth living.

The Indian Supreme Court has, through a series of rulings, established a battery of procedural safeguards for the implementation of passive euthanasia and advance medical directives. While the potential for abuse of this practice may never be fully eliminated, especially in the unregulated domain of private medical practice, a robust palliative care infrastructure, social services, and legal aid programs may help to ensure that a request for euthanasia is based on a free and uncoerced decision, and not on desperation.

Research Gap

Existing literature on euthanasia in India has concentrated on the doctrinal analysis of the decisions of the Supreme Court and the constitutional validity of the "right to die," which has culminated in the Common Cause case. However, a major lacuna in the literature has been the lack of a discussion on the practical implementation of guidelines on passive euthanasia, as recent studies have shown low awareness of advance directives among the public and health professionals, as well as procedural delays and inconsistent use of hospital ethics committees.[11]

Moreover, few studies have examined the connection between end of life decisions and the broader health system realities in India, including out of pocket expenditures and the availability of palliative care services, as well as state-specific policy uptake. Similarly, comparative studies of foreign laws have focused on a descriptive overview of foreign laws in isolation, rather than examining what pre-conditions would be required for the transplantation of similar laws in the Indian context. This paper hopes to bridge this gap by situating Indian doctrine in the context of an emerging body of literature on awareness and attitudes, as well as comparative studies.

Methodology and Data

Existing literature on euthanasia in India has concentrated on the doctrinal analysis of the decisions of the Supreme Court and the constitutional validity of the "right to die," which has culminated in the Common Cause case. However, a major lacuna in the literature has been the

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Core Observations

Firstly, the Indian Supreme Court has clearly distinguished between active and passive euthanasia, and incorporated passive euthanasia and advance directives under Article 21 of the Indian Constitution, which provides for a right to die with dignity, but has kept active euthanasia outside the scope of permissible constitutional space without legislation. This is consistent with the hypothesis that the Indian model is autonomy-sensitive but structurally cautious.

Secondly, the legal framework is largely judge-made and is yet to be underpinned by a comprehensive statute, and this has created ambiguity and uneven implementation. Research and policy commentaries have highlighted low levels of awareness of the legal position of passive euthanasia and advance directives among health care personnel and the public, and concerns about procedural complexities, lack of ethics committees in hospitals, and legal liability of doctors.

Thirdly, the data indicate that in reality, end of life decisions in India are influenced by economic factors and lack of palliative care, rather than by dignitarian autonomy, which is ethically suspect in terms of voluntariness. [12] Finally, a comparative analysis of jurisdictions that permit active euthanasia or physician-assisted suicide has shown that these jurisdictions

[12] Helga Kuhse and Peter Singer, A Companion to Bioethics (2nd edn, Blackwell 2009).

have a more developed statutory framework, reporting and review mechanisms, and availability of palliative care, which is not yet the case in India.

International Comparative Framework

If we compare India's euthanasia regime with the Dutch and Belgian models, we find that India's euthanasia regime is narrower in scope and wider in justification. While the Dutch and Belgian models allow for active euthanasia and assisted suicide under specific criteria, the Indian model draws a hard line on active euthanasia and allows only for passive euthanasia and advance medical directives through judicial guidelines, but not through parliamentary legislation.

However, Indian jurisprudence is uniquely rights-based in its approach, emphasizing the position of end-of-life decisions at the heart of Article 21 and their connection with the right of privacy, integrity of the body, and dignity. In terms of the readiness of the system, there is a body of research indicating that the review and reporting approach that is integral to the Dutch and Belgian systems has no equivalent in India. Ethics committees in hospitals and the development of palliative care services in India are in a poor state of development. Therefore, while the foreign models provide a useful framework in terms of designing a system of end-of-life care in India, the transplantation of the active euthanasia approach without the development of the health system is premature.

Recommendations and roadmap

The analysis points to a phased approach rather than an immediate move towards full-scale legalisation of active euthanasia. In the short term, Parliament can enact a comprehensive End of Life Care and Passive Euthanasia Act codifying the Common Cause approach, including definitions of key terms such as "futility" and "best interests" of the patient, clarifying criminal law immunities for physicians who adhere to prescribed procedures, and including advance directives within medical practice.

At the same time, national and state health departments can develop and implement palliative care services, including building on existing guidelines and consensus documents, and include end of life communication and ethics within medical and nursing education. Public information campaigns and simplified formats for advance directives can ensure that the right to a dignified death is a lived experience rather than a purely theological or doctrinal one.

It is only once these foundational elements of clear law, strong palliative care, ethics support, and data-driven oversight are firmly in place that India should even consider engaging in a public, parliamentary-level debate about whether some form of physician-assisted dying or active euthanasia might be normatively and institutionally possible.[122] Until that point, the most pressing need remains to build upon the current passive euthanasia regime, to safeguard vulnerable patients from coercive pressures, and to ensure that any decisions made are autonomy-enhancing.

X. Conclusion

The debate on the legality of euthanasia challenges the courts and the legislature to make difficult choices in the assessment of the value of human life, suffering, and autonomy and vulnerability. The distinction between active and passive euthanasia, while philosophically problematic, has become a conceptual framework for many jurisdictions, including India, to allow for end-of-life autonomy in limited circumstances while still adhering to the general prohibition of intentional killing. In the Indian context, the evolution from P. Rathinam and Gian Kaur to Aruna Shanbaug and Common Cause reflects a progressive shift from the general rejection of the "right to die" to the subtler acceptance of the "right to die with dignity" through passive euthanasia and advance directives under Article 21.

It may be noted that countries like the Netherlands and Belgium, which have allowed some form of active euthanasia and assisted suicide, have chosen a different path for themselves, and it remains to be seen whether this path, which emphasizes the withdrawal of futile treatment, would be adhered to in the long run and give way to a broader statutory framework or not. Be that as it may, it is apparent that the integrity of the Indian framework for end-of-life decisions depends not only on its judicial parameters but also on its investment in palliative care, awareness of patient rights, and the protection of vulnerable patients from exploitation and neglect. Ultimately, what must be aimed at is a framework that neither prolongs suffering in the name of abstract sanctity of life nor facilitates death in the face of living possibilities, but one that seeks to respect the complex and relational nature of human dignity at the end of life.

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