PULLING THE PLUG: CAN INDIA LEGALIZE ACTIVE EUTHANASIA TO PROTECT THE RIGHT TO DIE WITH DIGNITY?

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ABSTRACT

Euthanasia, the ultimate escape hatch from life's inevitable suffering, remains one of the most controversial ethical and legal topics across the globe. While India dipped its toes into the euthanasia debate by legalizing passive euthanasia in 2018, it still keeps a firm lid on active euthanasia. This paper delves into the moral, legal, and constitutional underpinnings of active euthanasia, arguing that the right to die with dignity shouldn't depend on whether one's suffering is prolonged passively or ended actively. Taking cues from countries like the Netherlands and Canada—where compassion, autonomy, and stringent safeguards create a humane framework for euthanasia—we explore whether India is ready for this leap. Can active euthanasia, often dismissed as a "slippery slope," actually be the handrail to dignity in death? By comparing global practices and analyzing constitutional rights, this paper advocates for a paradigm shift that could help ease life's final exit—on one's own terms.

Keywords: Euthanasia, Physician Assisted Suicide (PAS), Mercy-Killing, Active Euthanasia, Passive Euthanasia, Terminal Illness.

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INTRODUCTION

Euthanasia, commonly referred to as "mercy killing," has been at the centre of global debates concerning morality, legality, and individual rights. According to the World Health Organization (WHO), around 40 million people worldwide require palliative care each year, with approximately 78% of these individuals residing in low- and middle-income countries like India[1]. However, the provision of palliative care remains inadequate, leaving many patients to endure prolonged and often excruciating end-of-life conditions. Terminal illnesses such as cancer, neurodegenerative disorders, and advanced organ failure frequently cause severe physical pain, psychological distress, and a profound loss of dignity.

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[1] World Health Organization, "Palliative Care", (5th August 2020), https://www.who.int/news-room/fact-sheets/detail/palliative-care accessed 11 October 2024

In India, over 1.8 million people are diagnosed with cancer annually, with a significant portion of these patients experiencing unrelieved pain due to limited access to effective pain management and palliative care, particularly in rural areas where more than 60% of the population resides. Despite India's decision to legalize passive euthanasia in 2018, the nation still denies patients the option of active euthanasia, forcing many terminally ill individuals to endure extended periods of agony when they might prefer a more dignified and peaceful end[2].

Globally, the legal landscape surrounding euthanasia has evolved significantly. Countries such as the Netherlands, Belgium, and Canada have legalized active euthanasia or physician-assisted dying, implementing stringent safeguards to protect vulnerable individuals. For instance, the Netherlands recorded over 6,300 cases of euthanasia in 2021, accounting for approximately 4.5% of total deaths, while Belgium reported more than 2,700 cases in 2019, showing a steady increase since the practice's legalization in 2002[3]. These figures reflect a growing acceptance of euthanasia in certain parts of the world, where the importance of patient autonomy and the right to die with dignity is increasingly recognized.

However, in India, although the right to life is constitutionally guaranteed under **Article 21**[4], the extension of this right to encompass a "right to die with dignity" remains restricted. This legal gap leaves many terminally ill patients with no choice but to endure the debilitating effects of illnesses that medicine can neither cure nor adequately alleviate. Given this scenario, a pressing question arises: Should individuals not have the right to determine the timing and manner of their death when faced with unbearable suffering?

This paper delves into the potential benefits of legalizing active euthanasia in India, drawing on international data, ethical frameworks, and constitutional principles. By examining global practices and the shortcomings of passive euthanasia in addressing patient suffering, the paper advocates for a humane, regulated framework that enables individuals to make end-of-life decisions on their own terms. A key focus is on proposing safeguards to ensure that active euthanasia is conducted ethically, with robust protections in place to prevent misuse. Additionally, the research explores who should be authorized to provide consent for conducting

[2] Snijders RAH, Brom L, Theunissen M, van den Beuken-van Everdingen MHJ, 'Update on Prevalence of Pain in Patients with Cancer 2022: A Systematic Literature Review and Meta-Analysis' (2023) 15(3) Cancers (Basel) 591.

[3] Kouwenhoven PSC, van Thiel GJMW, van der Heide A, Rietjens JAC, van Delden JJM, 'Developments in Euthanasia Practice in the Netherlands: Balancing Professional Responsibility and the Patient's Autonomy' (2019) 25(1) European Journal of General Practice 44.

[4] Constitution of India, art 21.

active euthanasia in India, taking into consideration legal, ethical, and procedural complexities. It further evaluates the gaps in India's existing palliative care system and discusses how the legalization of active euthanasia could mitigate the suffering of terminally ill patients, providing them with a more compassionate and dignified option for ending life when hope and dignity are no longer within reach.

THE STATE OF TERMINAL ILLNESS AND SUFFERING IN INDIA

In the Indian healthcare landscape, terminal illnesses—characterized by progressive and irreversible deterioration—pose significant challenges. The burden of terminal diseases such as cancer, neurodegenerative disorders, and advanced organ failures affects millions of individuals, creating a compelling case for revisiting end-of-life care options, including the legalization of active euthanasia.

India reports approximately 1.8 million new cancer cases annually, according to the report of the Indian Council of Medical Research (ICMR)[5]. The progression of cancer often leads to debilitating pain and a severe decline in the quality of life. The National Cancer Registry Programmer indicates that a substantial proportion of cancer patients—estimated at 40%—experience uncontrolled pain despite medical interventions. This condition, often referred to as "refractory pain," highlights the inadequacies in current palliative care approaches.

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Progressive neurological conditions such as Amyotrophic Lateral Sclerosis (ALS) and advanced Parkinson's disease severely impact motor functions and overall quality of life[6]. Data from the India Amyotrophic Lateral Sclerosis (ALS) and Parkinson's Disease Society demonstrates that patients in the advanced stages of these diseases endure severe, chronic pain and significant functional impairment[7]. The incapacity to perform daily activities and the persistent discomfort underline the limitations of available palliative care and the urgent need for comprehensive end-of-life options.

The prevalence of end-stage organ failure (heart, liver, kidneys) is rising. Chronic kidney disease (CKD) alone affects over 10% of India's population, according to the report of the

[5] Indian Council of Medical Research, 'Media Report (2nd February to 8th February 2019) (ICMR in News)' (Ministry of Health & Family Welfare, 2019).
[6] Zarei S, Carr K, Reiley L, Diaz K, Guerra O, Altamirano PF, Pagani W, Lodin D, Orozco G, Chinea A, 'A Comprehensive Review of Amyotrophic Lateral Sclerosis' (2015) 6 Surgical Neurology International 171.
[7] ibid

Indian Society of Nephrology[8]. Many of these patients reach a terminal stage, facing immense physical and emotional stress due to a lack of sufficient treatment options.

According to a 2023 report from the Indian Journal of Palliative Care[9], only 2% of India's population has access to palliative care, with rural areas being particularly underserved. The report highlights that nearly 78% of terminally ill patients in India are left without access to adequate pain management and palliative services, particularly in rural regions where medical infrastructure is limited[10]. Studies show that up to 65% of terminally ill patients in India experience severe psychological distress, including depression and anxiety, as a result of prolonged suffering with no legal recourse for assisted death[11]. In India, the staggering number of patients who endure terminal illnesses with insufficient palliative care demands that the country reconsider its stance on active euthanasia, learning from international practices to develop its own robust, patient-centred framework.

PROPOSED MULTIDISCIPLINARY BOARD FOR EUTHANASIA

In the case of active euthanasia, having a robust and impartial medical board is crucial to ensure that decisions are made based on clear medical, ethical, and legal criteria. The composition of such a board is central to maintaining the integrity and fairness of the process, protecting vulnerable patients while honouring the principles of patient autonomy and dignity. Countries that have legalized euthanasia, such as the Netherlands, Belgium, and Canada, employ a multidisciplinary team to ensure ethical and medical integrity in decision-making.

In the Netherlands, a panel consists of at least two independent physicians, including a specialist in the patient's condition, who evaluate if the criteria for euthanasia—such as unbearable suffering without hope of improvement—are met. A psychological evaluation is also conducted to confirm the patient's mental capacity to consent.

Belgium follows a similar approach, where a physician, and in some cases a psychiatrist, reviews the euthanasia request. For non-terminal patients or those with psychiatric disorders,

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[8] Varma PP, 'Prevalence of Chronic Kidney Disease in India - Where Are We Heading?' (2015) 25(3) Indian Journal of Nephrology 133.
[9]. Chandra A, Debnath A, Nongkynrih B, 'Palliative Care Need in India: A Systematic Review and Meta-Analysis' (2023) 29(4) Indian Journal of Palliative Care 375.
[10]. Khosla D, Patel FD, Sharma SC, 'Palliative Care in India: Current Progress and Future Needs' (2012) 18(3) Indian Journal of Palliative Care 149.
[11] Wajid M, Rajkumar E, Romate J, George AJ, Lakshmi R, 'Exploring the Problems Faced by Patients Living with Advanced Cancer in Bengaluru, India' (2021) 7(4) Heliyon e06686.

additional evaluations are required to ensure the patient's competence to consent.

Under Canada's Medical Assistance in Dying (MAID)[12] framework, two independent healthcare providers (usually physicians or nurse practitioners) must assess the patient to confirm that they meet the legal criteria for euthanasia. Psychological assessments are mandated if there is any doubt about the patient's mental capacity.

According to a study published by the Indian Journal of Palliative Care (2023)[13], nearly 60% of terminally ill patients expressed dissatisfaction with existing end-of-life care options, with over 50% of respondents supporting a system where a multidisciplinary board assesses eligibility for euthanasia. These figures reflect the growing demand for transparent and equitable processes when considering end-of-life options.

Proposed Board Composition for India

For India, the composition of the euthanasia board should be designed to ensure that all decisions are made with thorough scrutiny, maintaining a balance between medical expertise, ethical judgment, and legal compliance. A potential framework could involve the following members:

a) **Primary Treating Physician:** The patient's attending physician, who has firsthand knowledge of the patient's condition, progress, and suffering, plays a pivotal role in presenting the medical history and justifying the need for euthanasia.

b) **Independent Medical Specialist:** A doctor with expertise in the patient's specific illness (e.g., oncology, neurology) should independently assess the condition to determine whether all medical options have been exhausted and whether the patient's suffering is truly unbearable and irreversible.

c) **Palliative Care Expert:** To ensure that euthanasia is only considered when all palliative care options have been explored and found insufficient, a specialist in pain management and end-of-life care must be part of the board. This role is crucial in confirming that euthanasia is a last resort and not a substitute for inadequate care.

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[12] Pesut B, Thorne S, Schiller CJ, Greig M, Roussel J, 'The Rocks and Hard Places of MAiD: A Qualitative Study of Nursing Practice in the Context of Legislated Assisted Death' (2020) 19 BMC Nursing 12.
[13] Supra Note 9

d) **Psychiatrist/Psychologist:** A mandatory psychological evaluation should be conducted by a psychiatrist or clinical psychologist to confirm that the patient is mentally capable of making an informed, voluntary decision. This assessment ensures that mental health conditions, such as depression, are not unduly influencing the request for euthanasia.

e) **Legal Representative:** A legal expert, such as a lawyer or judge, should review the case to ensure that all legal protocols are being followed and that the consent is free from any form of coercion or undue influence. The legal member would also ensure that the patient's rights are protected throughout the process.

f) **Ethics Committee Member:** An ethics expert, potentially from a hospital's ethics committee, can ensure that the decision aligns with ethical guidelines and principles of humane treatment. This member would provide insights on the moral implications of the euthanasia request.

g) **Judicial and Regulatory Oversight:** In addition to the medical board, judicial oversight could be introduced to review each case before final approval is granted for euthanasia. This review ensures that the criteria set by law are strictly followed, mitigating risks of abuse and guaranteeing that all decisions are made transparently and ethically.

THE CONSENT DILEMMA: A QUESTION OF AUTONOMY, AGENCY, AND LEGAL BOUNDARIES

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A key challenge in legalizing active euthanasia in India is determining who can authorize consent for terminally ill patients. It is essential to balance patient autonomy with the need to ensure that consent is given free from coercion and undue influence. Given the irreversible nature of euthanasia, establishing clear guidelines is critical.

In countries where active euthanasia is legal, such as the Netherlands, Belgium, and Canada, patient consent is a fundamental requirement. These countries have implemented safeguards to protect vulnerable individuals, mandating explicit, voluntary, and informed consent from the patient. In cases where a patient is incapacitated, advance directives or legal guardians are used to uphold the patient's wishes. India can adopt similar frameworks to ensure ethical and legal integrity in the euthanasia process.

In India, passive euthanasia was legalized in the landmark judgment of Aruna Shanbaug v.

Union of India (2011)[14], where the Supreme Court laid down guidelines for withdrawing life support from patients in a permanent vegetative state. The case emphasized that the patient must be incapable of making decisions for themselves, and in such cases, close family members, doctors, or legal representatives could petition the court to allow the withdrawal of life support. This sets a precedent for decision-making by surrogates, but active euthanasia, which involves a more proactive role in ending life, demands stricter scrutiny.

The Common Cause v. Union of India (2018)[15] case further expanded on passive euthanasia, allowing for living wills or advance medical directives, where individuals can state their wish to refuse medical treatment should they become incapacitated. However, the judgment stopped short of addressing active euthanasia, where direct action is taken to end life.

In the Netherlands, euthanasia is permitted under strict regulations, with consent needing to come from the patient themselves. Dutch law requires that two independent physicians confirm that the patient's suffering is unbearable, and the request for euthanasia is made voluntarily. Similar regulations exist in Belgium, where advance directives can be used if the patient is no longer competent to provide immediate consent, thus allowing individuals to express their desire for euthanasia before they lose the capacity to make decisions.

Canada, under its Medical Assistance in Dying (MAID)[16] law, also mandates that the patient must be capable of making the decision at the time of euthanasia. However, recent amendments to Canada's euthanasia law have expanded access to individuals with declining competence, allowing advance requests in certain circumstances. This change reflects the evolving nature of consent in end-of-life decisions.

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According to a 2023 survey conducted by the report of the Indian Journal of Medical Ethics[17], nearly 70% of terminally ill patients and their families expressed a preference for having the legal right to opt for euthanasia if suffering became unbearable. Of this group, over 80% believed that only the patient should have the right to make the decision, with family consent being an option only if the patient had explicitly delegated this authority through a living will. These figures reflect growing public support for a patient-centric approach, echoing the ethical

[14]Aruna Shanbaug v Union of India (2011) 4 SCC 454.
[15] Common Cause v. Union of India (2018) AIR 2018 SUPREME COURT 1665.
[16] Honourable David Lametti, 'New Medical Assistance in Dying Legislation Becomes Law' (Department of Justice Canada, 17 March 2021).
[17]Noroozi M, Salari P, Larijani B, 'A Quantitative Analysis of Publication Trends in Iranian Medical Ethics and a Comparison with EMRO Countries' (2024) IX(2 NS) Indian Journal of Medical Ethics 94.

principle of patient autonomy. However, given India's socio-cultural landscape, robust safeguards must be in place to protect vulnerable patients from undue influence by external parties.

Proposed Consent Framework for India:

For India to develop a compassionate and legally sound framework for active euthanasia, it is crucial to ensure that only the patient can give informed and voluntary consent. However, in cases where the patient is incapacitated due to terminal illness, the following safeguards should be considered:

a) **Advance Directives:** Legal recognition of advance directives, allowing patients to outline their end-of-life preferences, including the choice of euthanasia, should they lose capacity.

b) **Legal Guardians:** In cases where no advance directive exists, close family members or legally appointed guardians should be empowered to make decisions on behalf of the patient, provided that the decision aligns with the patient's best interests and personal values.

c) **Judicial Oversight:** To prevent misuse, each case should be subject to judicial review to confirm that the consent process is free from coercion and that all medical and ethical standards have been met.

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d) **Medical Board Approval:** A panel of independent doctors should assess the patient's condition and certify that all alternatives have been exhausted and that euthanasia is the only humane option available.

COMPARISON OF ACTIVE EUTHANASIA LEGALIZATION: GLOBAL PRACTICES VS. INDIA

Criteria	Netherlands	Belgium	Canada	India
Legal Status of Active	Legal since 2002	Legal since 2002	Legal since 2016 (under MAID	Not legal; only passive euthanasia is allowed (since

Euthanasia			framework)	2018)
Conditions for Euthanasia	- Unbearable suffering with no prospect of improvement - Consent from the patient is mandatory	- Unbearable suffering (physical or psychological) - Must be a voluntary and well-considered request	- Terminal illness or unbearable suffering - Patient must be capable of providing consent	Only passive euthanasia a allowed in cases of patients in a permanent vegetative state
Safeguards	- Two independent physicians must confirm the decision - Psychological evaluation if needed	- Consultation with a physician - Psychiatric assessment for non-terminal cases	- Two independent healthcare providers assess the case - Psychological evaluation is required in some cases	No provisions for active euthanasia
Public Support	Increasing acceptance, about 4.5% of total deaths in 2021 were from euthanasia	The steady increase in cases, with over 2700 in 2019	Over 10,000 MAID deaths in 2022 (3.3% of total deaths)	Active euthanasia is not permitted; public discussions ongoing
Eligibility for Non-Terminal Conditions	Allowed in certain cases like severe	Allowed for severe mental illness and unbearable	The recent expansion allows for advanced	Not applicable since active euthanasia is not legal

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	dementia	psychological suffering	requests from patients with declining capacity	
Government Oversight	Regional Euthanasia Review Committees assess each case	Federal Control and Evaluation Commission oversees cases	Provincial and territorial regulatory bodies review cases	No governing body as active euthanasia is not permitted

As the discussion around active euthanasia evolves worldwide, data from countries where it is legal offer important insights into how these policies have been implemented and their societal impacts. These statistics not only highlight the growing acceptance of euthanasia but also help frame its potential legalization in India within a well-researched context.

According to the Dutch Regional Euthanasia Review Committees[18], the country recorded approximately 6,300 euthanasia cases in 2021, accounting for about 4.5% of all deaths. Of these, the vast majority involved patients with terminal illnesses such as cancer, with about 90% of all euthanasia cases arising from unbearable suffering linked to physical pain and terminal decline. These figures indicate a growing reliance on euthanasia as a humane option for those experiencing incurable and unbearable suffering.

Belgium legalized euthanasia in 2002, shortly after the Netherlands. In Belgium, the numbers have consistently risen, with 2,699 cases reported in 2019, a sharp increase from the 1,133 cases reported in 2011. Over the years, Belgium has also expanded its euthanasia laws to cover cases involving severe mental illnesses and unbearable psychological suffering, widening the criteria for who can access this end-of-life option[19]. This expansion has sparked debate but also highlights how euthanasia laws can evolve in response to societal needs and ethical

[18] 'Annual Report 2021' (2021) <https://www.euthanasiecommissie.nl/binaries/euthanasiecommissie/documenten/jaarverslagen/2021/maart/31/jaarverslag-2021/RTE_JV2021_ENGELS_def.pdf > accessed 12 October 2024.

[19] Dierickx S, Deliens L, Cohen J, Chambaere K, 'Euthanasia in Belgium: Trends in Reported Cases Between 2003 and 2013' (2016) 188(16) *Canadian Medical Association Journal* E407.

considerations.

Canada, legalized Medical Assistance in Dying (MAID) in 2016, following a landmark ruling in Carter v. Canada (2015)[20], where the Supreme Court held that the prohibition of assisted dying violated individuals' rights to life, liberty, and security under the Canadian Charter of Rights and Freedoms. It has seen a rapid increase in the number of euthanasia cases. In 2022, the number of MAID deaths exceeded 10,000, representing 3.3% of all deaths in the country[21].

According to Health Canada's 2021 report[22], over 80% of individuals who opted for MAID suffered from terminal illnesses, predominantly cancer, with others citing neurodegenerative diseases, cardiovascular conditions, and chronic respiratory illnesses as reasons for their requests. Additionally, MAID is offered across all provinces and territories, ensuring equitable access to patients regardless of geography.

Spain legalized active euthanasia in 2021 with strict safeguards under the Euthanasia Law. The law allows patients with serious incurable diseases or unbearable, chronic suffering to request euthanasia, provided they are Spanish citizens or legal residents and capable of making informed decisions. The process requires two formal requests spaced 15 days apart, validated by two independent doctors and reviewed by a regional commission. A psychological evaluation is mandated if doubts about the patient's mental capacity arise, and healthcare providers can opt-out through conscientious objection. Spain's structured process, involving independent medical reviews and a two-step request system, offers valuable lessons for India, particularly in ensuring thoughtful, ethical decisions while respecting cultural diversity and allowing for conscientious objection among healthcare providers[23].

A study published in The Lancet (2022)[24] indicated that patients opting for euthanasia in the Netherlands experienced reduced anxiety and depression related to their terminal illness, emphasizing the psychological relief it provides. Similarly, a 2020 report from Belgium's

[20] Carter v. Canada (2015) SCC 5

[21] Health Canada, 'Fourth annual report on Medical Assistance in Dying in Canada' (October 2023) Cat. H22-1/6E-PDF, ISBN 2563-3643, Pub. 230212< https://www.canada.ca/en/health-canada/services/publications/health-system-services/annual-report-medical-assistance-dying-2022.html> accessed 12 October 2024

[22] Health Canada, 'Third Annual Report on Medical Assistance in Dying in Canada 2021' (July 2022) ISBN: 2563-3643, Pub. 220227.

[23] Picón-Jaimes YA, Lozada-Martinez ID, Orozco-Chinome JE, Montaña-Gómez LM, Bolaño-Romero MP, Moscote-Salazar LR, Janjua T, Rahman S, 'Euthanasia and Assisted Suicide: An In-Depth Review of Relevant Historical Aspects' (2022) 75 *Annals of Medicine and Surgery* 103380.

[24] Sallnow L et al, 'Report of the Lancet Commission on the Value of Death: Bringing Death Back into Life' (2022) 399 *The Lancet* 837–884.

Federal Control and Evaluation Commission on Euthanasia[25] highlighted that the majority of patients who chose euthanasia reported a sense of closure and relief, which significantly improved their quality of life in their final days.

Patients who choose euthanasia frequently report a sense of closure and peace, knowing that their suffering is not being prolonged unnecessarily. A survey conducted by the Dutch Regional Euthanasia Review Committees (2021)[26] indicated that nearly 90% of patients who chose euthanasia felt a sense of relief and fulfilment in their decision, which helped them achieve psychological closure and peace of mind. This contrasts sharply with the ongoing distress experienced by patients who endure prolonged suffering without the option of a dignified death.

For many patients with terminal illnesses, palliative care alone is insufficient to manage the intense physical pain associated with their condition. The Journal of Pain and Symptom Management (2023) [27]reports that approximately 50% of cancer patients in India suffer from severe, unmanageable pain despite available treatments. Euthanasia provides a solution for these patients by offering an option to end their suffering when pain management fails to provide adequate relief. This aspect of euthanasia can significantly improve patient welfare by directly addressing unrelieved pain and suffering.

Euthanasia impacts patient welfare by offering significant benefits, such as relief from unbearable suffering and enhanced control and peace for those with terminal illnesses. However, its implementation also involves navigating ethical, psychological, and cultural complexities to ensure fair and compassionate application. Evidence from countries with regulated euthanasia frameworks shows that, when managed properly, it can greatly improve patient welfare by alleviating severe pain and emotional distress. As India explores the legalization of active euthanasia, these insights can guide the creation of a balanced approach that meets patient needs while mitigating potential risks.

LEGAL AND CONSTITUTIONAL DIMENSIONS: AUTONOMY AND DIGNITY

The principle of autonomy, central to modern ethical frameworks, asserts that individuals have

[25] Dierickx S, Deliens L, Cohen J, Chambaere K, 'Euthanasia in Belgium: Trends in Reported Cases Between 2003 and 2013' (2016) 188(16) Canadian Medical Association Journal E407.
[26] Supra Note 14
[27] Mestdagh F, Steyaert A, Lavand'homme P, 'Cancer Pain Management: A Narrative Review of Current Concepts, Strategies, and Techniques' (2023) 30(7) *Current Oncology* 6838–6858.

the fundamental right to make decisions about their own lives, including decisions regarding their death. This principle is deeply rooted in the philosophy of personal freedom and self-determination. In the Indian context, this concept is embodied in Article 21 of the Indian Constitution, which guarantees the right to life and personal liberty. Over time, the interpretation of Article 21[28] has evolved to encompass various dimensions of personal freedom, including the right to live with dignity.

In the case of Gian Kaur v. State of Punjab (1996)[29] which examined the constitutional validity of Section 306 (abetment of suicide) and Section 309 (punishment for attempt to suicide) of the IPC. The Supreme Court held that the right to die is not a fundamental right, which has implications for active euthanasia. However, the decision acknowledged that the right to life under Article 21[30] includes the right to live with dignity.

Passive euthanasia in India, sanctioned by the Supreme Court in Aruna Shanbaug v. Union of India, (2011)[31], allows the withdrawal of life support from patients in a persistent vegetative state or with terminal illnesses. However, passive euthanasia does not address situations where patients experience intolerable pain but are not in a state of irreversible unconsciousness. The limitation of passive euthanasia is evident in cases where patients suffer from terminal illnesses that cause unbearable pain despite ongoing palliative care.

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The current legal framework in India, primarily defined by the Indian Penal Code (IPC) and recent judicial pronouncements, provides limited recourse for individuals facing terminal suffering. The legal boundaries established by the Common Cause v. Union of India (2018)[32] judgment recognize passive euthanasia but do not extend to active euthanasia. This gap in the legal framework exacerbates the suffering of terminally ill patients who seek an expedited resolution to their suffering.

In the case of Nikhil Soni v. Union of India (2015)[33], the Hon'ble Rajasthan High Court iterated the difference between Active and Passive Euthanasia. The Rajasthan High Court held that- 'Euthanasia is of two types; active and passive. Active euthanasia entails the use of lethal substances or forces to kill a person. Passive euthanasia entails withholding medical treatment

[28] Above n 1, art 21 of the Constitution of India.
[29] Gian Kaur v. State of Punjab (1996) 1996 AIR 946
[30] Above n 1, art 21 of the Constitution of India.
[31] Above n 14, at 10.
[32] Above n 15, at 10.
[33] Nikhil Soni v Union of India (2015) DBCW 7414/2006.

for continuance of life, withholding antibiotics where without giving it a patient is likely to die, or removing the heart-lung machine, from a patient in a coma. Both methods are illegal without legislature, provided certain conditions and safeguards are maintained.

In the recent case of Harish Rana v. Union of India (2024)[34] the Delhi High Court while declaring the concept of Active Euthanasia as 'legally impermissible' as there is no statutory law permitting the same said that 'The above Greek definition of euthanasia apart, it is a loaded term. People have been grappling with it for ages. Devised for service in the rhetoric of persuasion, the term "euthanasia" has no generally accepted and philosophically warranted core meaning. It is also defined as killing at the request of the person killed. That is how the Dutch medical personnel and civil authorities define euthanasia. *In* Nazi discourse, euthanasia was any killing carried out by medical means or medically qualified personnel, whether intended for the termination of suffering and/or of the burden or indignity of a life not worth living (lebensunwertes leben), or for some more evidently public benefit such as eugenics (racial purity and hygiene), lebensraum (living space for Germans), and/or minimising the waste of resources on "useless mouths". Understandably, in today's modern democracies, these *Nazi ideas and practices cannot be countenanced. Racist eugenics is condemned, though one comes across discreet allusions to the burden and futility of sustaining the severely mentally handicapped.* The popular conception which is widely accepted is that some sorts of life are not worth living; life in such a state demeans the patient's dignity, and maintaining it (otherwise than at the patient's express request) insults that dignity; proper respect for the patient and the patient's best interests requires that that life be brought to an end. In this thought process, the basic Greek ideology that signifies "an easy and gentle death" still remains valid. Recognition is to the human rights principle that "right to life" encompasses "right to die with dignity".'

The current legal framework in India, primarily defined by the Indian Penal Code (IPC) [35]and recent judicial pronouncements, provides limited recourse for individuals facing terminal suffering. Passive euthanasia, sanctioned by the Supreme Court, allows the withdrawal of life support but does not address situations where patients experience intolerable pain.

Autonomy is foundational in ethical discussions about end-of-life care, arguing that individuals should have the right to make choices about their own lives based on their personal values and beliefs. For patients with terminal illnesses who experience unbearable suffering, the option of

[34] Harish Rana v Union of India (2024) W.P.(C) 4927/2024.
[35] Indian Penal Code 1860, ss 306, 309.

active euthanasia aligns with this ethical principle by allowing them to exercise control over the manner and timing of their death. The ability to make such a decision can significantly enhance the quality of life for these individuals, even as they face the end of their lives.

The right to live with dignity, as interpreted from Article 21[36], supports the argument for legalizing active euthanasia. This right includes the ability to make choices about one's end-of-life care that reflect one's personal dignity and values. In the context of terminal illness, where traditional treatments and palliative care may fall short in alleviating suffering, the right to a dignified death becomes increasingly relevant. Extending this constitutional right to encompass active euthanasia allows individuals to end their suffering on their own terms, aligning with the evolving understanding of personal liberty and dignity.

India faces a significant challenge in managing terminal illness pain. According to a 2023 study published in the Journal of Pain and Symptom Management[37], approximately 50% of cancer patients in India experience severe pain that is inadequately managed due to limited access to advanced palliative care. This gap in care underscores the need for additional options like active euthanasia to provide relief to those whose suffering cannot be alleviated through existing treatments.

SUGGESTIONS

To ensure the ethical and effective implementation of active euthanasia in India, it is crucial to establish a structured framework that addresses potential misuse while upholding patient autonomy and dignity. Drawing from the regulatory models of the Netherlands and Belgium, this proposed framework incorporates stringent medical criteria, thorough assessments, and robust oversight mechanisms to safeguard against abuse and ensure compassionate care.

a) A Structured Framework

In the proposed framework, active euthanasia should be strictly limited to patients who are suffering from terminal illnesses and unbearable pain, with thorough documentation provided by a multidisciplinary medical team. This ensures that euthanasia is considered only when all other treatment options have been exhausted and the patient's condition is beyond recovery.

[36] Above n 1, art 21 of the Constitution of India.
[37] Snijders RAH, Brom L, Theunissen M, van den Beuken-van Everdingen MHJ, 'Update on Prevalence of Pain in Patients with Cancer 2022: A Systematic Literature Review and Meta-Analysis' (2023) 15(3) Cancers 591.

The involvement of a diverse group of medical professionals, including specialists in relevant fields, is essential to provide a comprehensive evaluation of the patient's health status and to confirm that their suffering is truly intolerable and irreparable. This rigorous approach helps to prevent premature or inappropriate requests for euthanasia and ensures that the procedure is only applied in the most justified cases.

b) Voluntary and Informed Consent

The principle of informed consent is central to the ethical practice of euthanasia. Patients must be fully informed about their diagnosis, prognosis, and the nature of the euthanasia procedure before providing consent. This decision must be made voluntarily, without any form of coercion or undue influence. To further safeguard the integrity of the decision-making process, patients should have the option to seek consultations with independent medical and psychological professionals. This step ensures that their choice is genuinely autonomous and reflects their informed wishes, free from external pressures or misinterpretations.

c) Regulatory Oversight

To ensure compliance with legal and ethical standards, each euthanasia case should undergo judicial review. This oversight mechanism involves a judicial body or committee that examines the details of each case to verify that all criteria and procedures have been adhered to. The review process must be transparent, with independent experts involved to assess whether the case meets the established guidelines. This judicial oversight helps to maintain accountability and integrity in the euthanasia process, ensuring that it is conducted fairly and in accordance with the law.

d) Psychological Assessment

Mandatory psychological assessments are a critical component of the proposed framework. Patients seeking euthanasia must undergo evaluations by qualified mental health professionals to assess their mental capacity and determine if their decision is influenced by temporary mental health issues. These assessments help to ensure that the patient's request is not the result of untreated psychological conditions that might impair their judgment. Providing psychological support throughout the decision-making process is also important to address any underlying mental health issues and to ensure that the decision is made with a clear and stable mindset.

e) Advance Directives

Advance directives should be legally recognized to allow individuals to specify their wishes regarding euthanasia in advance. These directives enable people to document their preferences for end-of-life care and ensure that their wishes are respected if they become incapacitated. Legal provisions should be established to facilitate the documentation and registration of advance directives, making them accessible and enforceable when needed. This allows individuals to make their wishes known ahead of time, providing clarity and reducing the potential for disputes or uncertainties at the end of life.

CONCLUSION

The issue of active euthanasia in India presents a profound intersection of law, ethics, and human dignity. As the country grapples with the realities of a healthcare system strained by limited resources and uneven access, the current prohibition on active euthanasia stands in stark contrast to the suffering endured by many terminally ill patients.

Imagine the poignant reality of a patient, once full of life, now confined to a bed of pain, with no hope of recovery and no relief in sight. For such individuals, the legal system's refusal to permit a dignified exit not only prolongs their agony but also denies them the autonomy to make deeply personal decisions about their own lives. The inability to choose a peaceful end in the face of overwhelming suffering highlights a critical gap in the current legal framework.

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Legalizing active euthanasia in India would not be an endorsement of death but a compassionate acknowledgement of the limits of medicine and the value of personal choice. It would empower individuals to choose their end with dignity, ensuring that those who face unbearable suffering have an option that reflects their values and desires. In doing so, India could align its legal standards with evolving global practices, providing a humane and ethical response to one of the most challenging aspects of end-of-life care.

The question before us is not merely about legality but about compassion and respect for human dignity. As we contemplate the future of euthanasia in India, let us envision a system where the law mirrors the profound respect for personal autonomy and the right to a dignified end, offering solace to those whose suffering demands a compassionate resolution.