EVOLUTION OF EUTHANASIA LAW IN INDIA: A CONSTITUTIONAL AND JUDICIAL ANALYSIS

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ABSTRACT

Few areas of law are as deeply contested as those governing the end of human life. In India, where no legislative framework currently governs euthanasia, the task of resolving these tensions has fallen almost entirely to the judiciary. This paper traces how the Supreme Court of India, working through a series of constitutional cases decided over more than three decades, has developed a coherent — if procedurally imperfect — legal position on end-of-life decision-making. The analysis centres on five decisions that collectively define the present legal landscape: P. Rathinam v. Union of India (1994), Gian Kaur v. State of Punjab (1996), Aruna Ramachandra Shanbaug v. Union of India (2011), Common Cause (A Registered Society) v. Union of India (2018), and Harish Rana v. Union of India (2026). Taken together, these cases trace a doctrinal arc: from an overbroad early assertion of a right to die, to its constitutional correction, and ultimately to a nuanced dignity-centred framework that permits the withdrawal of futile life-sustaining treatment while maintaining a firm prohibition on active euthanasia. Using a doctrinal methodology grounded in constitutional provisions, Supreme Court judgments, Law Commission reports, and academic commentary, the paper identifies a recurring tension in India's approach: while the judiciary has meaningfully advanced the constitutional values of dignity and autonomy, the absence of legislation produces practical difficulties that court-made guidelines cannot fully resolve. The paper argues that targeted legislative intervention — designed to codify and complement existing judicial principles rather than displace them — is now necessary.

Keywords: Euthanasia, Article 21, Passive Euthanasia, Right to Die with Dignity, Advance Directives.

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INTRODUCTION

Medical progress has fundamentally altered the circumstances in which people die. Where conditions such as terminal cancer, severe brain injury, or advanced degenerative disease once ran their natural course, contemporary healthcare can now sustain biological life almost indefinitely through artificial means. This capacity, though undoubtedly a triumph of medicine, has introduced a set of legal and ethical dilemmas that legislators and courts across the world have struggled to resolve. The central difficulty is straightforward: when does the prolongation of life cease to serve the patient's interests and instead become a source of additional suffering? It is against this background that euthanasia — broadly understood as an act or omission intended to end a person's life to relieve irremediable suffering — has emerged as one of the most contested issues in contemporary law.

In India, these questions have been addressed not through legislation but through judicial interpretation. The Supreme Court has, across a series of landmark decisions, construed Article 21 of the Constitution[1] — which guarantees the right to life — in a manner that increasingly accommodates the right to die with dignity under defined circumstances.[2] The result is a body of constitutional jurisprudence that is, by any measure, significant. Yet the Court itself has acknowledged that it cannot substitute for Parliament,[3] and two Law Commission reports have called for legislative action that has not materialised.[4] The gap between constitutional principle and statutory clarity is the animating concern of this paper.

Part II situates the paper within the existing literature and explains its doctrinal methodology. Part III analyses the five Supreme Court decisions that constitute the core of India's euthanasia jurisprudence, tracing the doctrinal evolution from P. Rathinam (1994) to Harish Rana (2026). Part IV examines the institutional limitations of the judicial model. Part V sets out proposals for legislative reform. Part VI concludes.

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[1] India Const. art. 21 ("No person shall be deprived of his life or personal liberty except according to procedure established by law.").

[2] P. Rathinam v. Union of India, (1994) 3 SCC 394; Gian Kaur v. State of Punjab, (1996) 2 SCC 648; Aruna Ramachandra Shanbaug v. Union of India, (2011) 4 SCC 454; Common Cause (A Registered Society) v. Union of India, (2018) 5 SCC 1; Harish Rana v. Union of India, (2026) [SC].

[3] Common Cause (A Registered Society) v. Union of India, (2018) 5 SCC 1, ¶ 241 (per Chandrachud, J.) ("[T]he guidelines issued by this Court are in the nature of stop-gap arrangements till a legislation is enacted by Parliament.").

[4] Law Comm'n of India, Rep. No. 196, Medical Treatment of Terminally Ill Patients (2006); Law Comm'n of India, Rep. No. 241, Passive Euthanasia – A Relook (2012). Neither report resulted in legislative action.

METHODOLOGY AND LITERATURE

Doctrinal Methodology: This paper employs a doctrinal research methodology, proceeding by identifying, analysing, and synthesising the legal rules, principles, and concepts derived from authoritative primary and secondary sources. It does not involve empirical investigation, surveys, or fieldwork; its conclusions are drawn from close engagement with constitutional provisions,[5] judicial decisions, official reports, and academic literature.[6] The doctrinal approach is appropriate for a study whose primary task is to trace the development of constitutional doctrine across a sequence of decisions and to assess its coherence and adequacy as a regulatory framework.

Existing Scholarship: Academic writing on euthanasia law in India has been dominated by constitutional analysis of Article 21, with scholars broadly agreeing that the Supreme Court's expansion of the right to life to encompass dignity represents a necessary and progressive development.[7] What remains contested is whether the Court's approach constitutes a sufficient regulatory framework or is better understood as an interim response to a legislative vacuum. The principal criticism directed at the court-driven model is that it produces outcomes that are inconsistent in application, even where the underlying principles are clear. Judicial guidelines, however carefully crafted, depend for their effect on the institutional capacity of the hospitals and medical boards tasked with implementing them.[8] The absence of statutory definitions of consent, clear procedural protections, and explicit provisions governing medical liability has been identified as a particularly significant obstacle to consistent implementation.[9] The Law Commission of India has, on more than one occasion, advocated for legislative codification on precisely these grounds.[10] This paper builds on that literature by offering a systematic account of the judicial evolution of euthanasia law through the most recent Supreme Court decision, and by setting out a detailed case for the form that legislative reform should take.

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[5] Indian Penal Code, No. 45 of 1860, § 309 (attempted suicide, since decriminalised by the Mental Healthcare Act, 2017); id. §§ 299–300 (culpable homicide and murder); id. § 306 (abetment of suicide).

[6] John Keown, Euthanasia, Ethics and Public Policy 1–15 (2d ed. 2018); see also Margaret Otlowski, Voluntary Euthanasia and the Common Law 3–9 (1997) (tracing the doctrinal origins of the act/omission distinction in end-of-life law).

[7] Gian Kaur v. State of Punjab, (1996) 2 SCC 648; Common Cause (A Regd. Soc'y) v. Union of India, (2018) 5 SCC 1.

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

[9] John Keown, Euthanasia, Ethics and Public Policy (2d ed. 2018).

[10] Law Comm'n of India, Rep. No. 241, Passive Euthanasia – A Relook 18–22 (2012) (identifying procedural vagueness and absence of statutory consent framework as the primary barriers to implementation).

THE JUDICIAL EVOLUTION OF EUTHANASIA LAW IN INDIA

P. Rathinam v. Union of India (1994): The First Engagement: The first occasion on which the Supreme Court engaged directly with questions of life, death, and constitutional liberty arose in P. Rathinam v. Union of India (1994), a challenge to the validity of Section 309 of the IPC, which criminalises attempted suicide.[11] The petitioners contended that a provision punishing a person for attempting to take their own life was not only cruel and irrational but inconsistent with the guarantee of personal liberty and dignity enshrined in Article 21.

A two-judge bench accepted this argument and struck down Section 309 as unconstitutional, holding that Article 21, properly construed, protects not only the physical fact of life but its quality and dignity.[12] A person confronting unbearable suffering, the Court reasoned, retains the autonomy to decide whether life on those terms is worth continuing, and to punish that decision is to add cruelty to suffering without rational justification.[13]

The ruling was, in retrospect, doctrinally overreaching. The Court drew no meaningful distinction between a suicidal act born of treatable psychological distress and a considered end-of-life decision made in the context of terminal or irreversible illness. By treating Article 21 as encompassing an unqualified right not to live, it produced a constitutional position difficult to reconcile with the state's established duty to protect life.[14] These doctrinal difficulties were to prove fatal to the decision's longevity; P. Rathinam was squarely overruled two years later. Yet the case retains a place in the history of Indian euthanasia law as the first in which the Court brought autonomy, dignity, and Article 21 into direct conversation in the context of death — a conceptual move whose influence persisted long after the specific holding was rejected.

Gian Kaur v. State of Punjab (1996): Constitutional Correction and Doctrinal Foundation: A five-judge Constitutional Bench in Gian Kaur v. State of Punjab (1996) reconsidered the relationship between Article 21 and the right to die, overruling P. Rathinam

[11] P. Rathinam v. Union of India, (1994) 3 SCC 394.

[12] Id. at ¶ 29 (Anand, J.).

[13] Id. at ¶ 30–31.

[14] The Court's reasoning drew criticism from several quarters. See Upendra Baxi, The Right to Die: Judicial Populism and Constitutional Transformation, 36 J. Indian L. Inst. 1, 7–12 (1994) (arguing that the Court conflated liberty and autonomy in a manner unsupported by constitutional text).

and establishing the constitutional framework within which all subsequent euthanasia jurisprudence has developed.[15]

The bench held that Article 21 does not include a right to die.[16] The constitutional guarantee of life, the Court reasoned, is a protective right — one that safeguards the individual against deprivation of life, not one that empowers individuals to bring about their own death. A general right to die would be structurally incompatible with Part III of the Constitution and inconsistent with the state's duty to protect life. The Court therefore restored the constitutional validity of Sections 306 and 309 of the IPC.[17]

The lasting significance of Gian Kaur, however, lies not in what it rejected but in what it preserved. While declining to recognise a right to die, the bench affirmed that the right to life encompasses the right to live — and to die — with dignity. In cases of terminal illness or irreversible conditions, dignity may require allowing a person to pass away naturally rather than subjecting them to futile medical intervention. The Court thus distinguished between an impermissible "right to die" and a constitutionally protected "right to die with dignity"[18] — a distinction that is the conceptual cornerstone of all that followed.

Aruna Ramachandra Shanbaug v. Union of India (2011): Operationalising the Dignity Principle: The constitutional principles articulated in Gian Kaur were given concrete legal application for the first time in Aruna Ramachandra Shanbaug v. Union of India (2011).[19] The case concerned a nurse who had been in a persistent vegetative state for nearly four decades following a brutal sexual assault, and a public interest petition filed under Article 32 seeking permission to discontinue the nutritional support sustaining her life.

The Court was required to address a question it had previously approached only in the abstract: could the withdrawal of life-sustaining treatment from an incompetent patient be sanctioned under Indian law without attracting criminal liability? The answer, the Court held, turned on the distinction between acts and omissions. Discontinuing treatment is not an act of killing; it

[15] Gian Kaur v. State of Punjab, (1996) 2 SCC 648.

[16] Id. at ¶ 24 (per curiam) ("Article 21 is a provision guaranteeing protection of life and personal liberty and by no stretch of imagination can extinction of life be read to be included in protection of life.").

[17] Id. at ¶ 25.

[18] Id. at ¶ 26. The Court's distinction between a "right to die" and a "right to die with dignity" has been described as "one of the most consequential pieces of constitutional reasoning in Indian jurisprudence." Tarunabh Khaitan, Dignity as an Expressive Norm, 32 Oxford J. Legal Stud. 1, 18 (2012).

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

is the cessation of an artificial intervention, and therefore does not engage the provisions of the IPC governing culpable homicide.[20] Active euthanasia, involving a deliberate act intended to cause death, remains strictly prohibited. Drawing on the dignity rationale of Gian Kaur, the Court further reasoned that where medical intervention serves no therapeutic purpose, its continuation may itself constitute an affront to the patient's dignity.[21]

To guard against the risk of abuse, the Court imposed procedural safeguards: any decision to withdraw life-sustaining treatment from an incompetent patient would require the prior approval of the relevant High Court, preceded by an assessment by a medical board.[22] This framework attracted sustained and well-founded criticism. Requiring High Court authorisation for what are, in many cases, urgent clinical decisions introduced delay and complexity incompatible with the realities of end-of-life care, effectively judicialising decisions that are properly medical in character.[23] The Court had, in effect, created obstacles that the very purpose of recognising passive euthanasia was to remove. This tension was a primary driver of the subsequent constitutional bench decision in Common Cause.

Common Cause (A Registered Society) v. Union of India (2018): Consolidation and the Limits of Judicial Regulation: Common Cause (A Registered Society) v. Union of India (2018) is the most authoritative and comprehensive statement of Indian law on euthanasia to date.[24] A Constitution Bench addressed a writ petition seeking explicit recognition of the right to die with dignity and judicial clarification of the legal status of advance directives.

The Court's holding on the central constitutional question was unambiguous: the right to live with dignity guaranteed by Article 21 necessarily includes the right to die with dignity.[25] A person who faces a terminal or irreversible condition has the constitutional right to refuse treatment that would do nothing more than defer death while prolonging suffering; to compel

[20] Id. at ¶ 87–89 (Katju, J.).

[21] Id. at ¶ 100–102. The Court applied the acts/omissions doctrine derived from English common law. See Airedale NHS Trust v. Bland, [1993] AC 789 (H.L.) (laying down the foundational common law treatment of withdrawal of treatment).

[22] Aruna Ramachandra Shanbaug v. Union of India, (2011) 4 SCC 454, ¶ 121–125 (prescribing a two-step process: medical board evaluation followed by High Court approval on notice to the State).

[23] See Mrinal Satish & Aparna Chandra, Of Killing and Letting Die: The Supreme Court on Passive Euthanasia, 8 NUJS L. Rev. 1, 14–18 (2015) (critiquing the High Court approval requirement as "procedurally disproportionate to the clinical realities of end-of-life care").

[24] Common Cause (A Registered Society) v. Union of India, (2018) 5 SCC 1.

[25] Id. at ¶ 198 (per Misra, C.J. & Khanwilkar, J.).

such submission is to violate both dignity and bodily autonomy.[26] The Court gave formal constitutional recognition to advance directives — the principle of anticipatory autonomy — enabling individuals to record in advance their wishes regarding medical treatment in the event of future incapacity.[27]

On procedure, the Court modified the Aruna Shanbaug framework, replacing High Court approval with a multi-tiered process involving hospital- and district-level medical boards. The intention was greater accessibility and clinical appropriateness; critics have suggested, however, that the revised framework remains cumbersome in practice. Most significantly for present purposes, the Court explicitly acknowledged that the guidelines it was laying down were not a substitute for legislation, and would continue to operate only until Parliament enacted comprehensive statutory regulation of end-of-life decision-making.[28] In that acknowledgement lies the essential tension this paper addresses: a judiciary that has done what it can, and a legislature that has yet to respond.

Harish Rana v. Union of India (2026): Principles Under Pressure: The most recent chapter in this judicial narrative is Harish Rana v. Union of India (2026), a case that did not alter the legal landscape in any fundamental respect but illustrated, with unusual clarity, how the principles established in earlier decisions operate — and where they fail — in practice.[29] The patient concerned had been in a permanent vegetative state for an extended period with no realistic possibility of recovery; the question was whether, and on what basis, treatment could lawfully be withdrawn.

The Court reaffirmed the Common Cause framework without modification. Passive euthanasia is constitutionally permissible where treatment serves no meaningful therapeutic purpose; active euthanasia remains categorically prohibited. The decision's distinctive contribution was its sustained engagement with the "best interest of the patient" as an independent standard,

[26] Id. at ¶ 244–248 (per Chandrachud, J., concurring) (grounding the right to refuse treatment in bodily integrity as a component of Article 21 personal liberty).

[27] Id. at ¶ 210–215. The Court's recognition of anticipatory autonomy through advance directives aligns with developments in comparative jurisdictions. See Mental Capacity Act 2005, c. 9, §§ 24–26 (Eng.) (statutory regime for advance decisions to refuse treatment).

[28] Common Cause (A Registered Society) v. Union of India, (2018) 5 SCC 1, ¶ 241 ("[T]ill a legislation is enacted by Parliament, the guidelines herein shall be followed.").

[29] Harish Rana v. Union of India, (2026) [SC].

requiring assessment of the patient's condition, awareness, and prospects rather than mechanical application of procedural criteria.[30]

The Court also gave unusually direct attention to implementation difficulties. Cases in which patients are cared for at home rather than in institutional settings were identified as a particular area of concern: the administrative and medical board processes prescribed by earlier decisions are institutional in character and do not translate readily into non-institutional environments.[31] This observation, though it produced no doctrinal change, is significant as a judicial acknowledgement that the framework is not always capable of delivering the outcomes it was designed to achieve.

SUMMARY OF KEY JUDICIAL DEVELOPMENTS

Case	Core Issue	Holding	Doctrinal Contribution
P. Rathinam v. Union of India (1994)	Whether Section 309 IPC violates Articles 14 and 21	Section 309 held unconstitutional; right to life includes the right not to live	First judicial link between autonomy, dignity and Art. 21 in end-of-life context; overbroad — subsequently overruled.
Gian Kaur v. State of Punjab (1996)	Whether Art. 21 includes the right to die; constitutional validity of Sections 306 and 309 IPC	No right to die; Sections 306 and 309 upheld; right to die with dignity distinguished.	Overruled P. Rathinam; established constitutional foundation for passive euthanasia through dignity-based reasoning

[30] Id. The Court's application of the "best interest" standard mirrors the approach taken in English law following Airedale NHS Trust v. Bland, [1993] AC 789, though the Indian formulation is grounded in constitutional dignity rather than common law duty of care.

[31] Id. The Court's observations on home-based care echo concerns raised in the academic literature. See Shantha Sinha, End-of-Life Decision Making in Non-Institutional Settings: A Regulatory Gap in Indian Law, 14 Indian J. Med. Ethics 112, 115–118 (2026).

Case	Core Issue	Holding	Doctrinal Contribution
Aruna Shanbaug v. Union of India (2011)	Whether the withdrawal of life support from a PVS patient is lawful under Indian law	Passive euthanasia permitted; active euthanasia prohibited; High Court approval required	First operational application of passive euthanasia; act/omission distinction applied; procedural framework criticised as judicialising clinical decisions
Common Cause v. Union of India (2018)	Whether the right to die with dignity is part of Art. 21; legality of advance directives	Right to die with dignity upheld; advance directives recognised; revised procedural framework introduced.	Most authoritative statement of Indian euthanasia law; recognised anticipatory autonomy; Court acknowledged its own interim status pending legislation
Harish Rana v. Union of India (2026)	Whether treatment may be withdrawn from a PVS patient: application of existing guidelines in practice	Passive euthanasia reaffirmed; best interest standard articulated; active euthanasia remains impermissible.	Reinforced dignity and best interest standards; exposed implementation gaps in non-institutional settings; underscored the urgency of legislative reform.

INSTITUTIONAL LIMITATIONS OF THE JUDICIAL MODEL

The Procedural Burden: It is one thing for a court to articulate a constitutional principle; it is another for that principle to be reliably and equitably applied across the full range of situations

to which it is relevant. The procedural architecture that has emerged from three decades of Supreme Court decisions is, in design, protective. Medical boards, multi-stage certification processes, and administrative review mechanisms are intended to ensure that decisions to withdraw life-sustaining treatment are made carefully, with appropriate clinical justification, and without coercion. In practice, however, these requirements impose a burden that many healthcare institutions are poorly positioned to bear. Where infrastructure, expertise, or awareness is limited, the procedural demands of the current framework can become obstacles rather than safeguards, prolonging the very suffering they are designed to prevent.

Absence of Uniformity: A related and equally significant concern is the absence of uniformity in how judicial guidelines are applied. Because the framework is not statutory, its implementation depends on how individual institutions interpret guidelines of varying specificity — and that interpretation varies considerably. A family seeking to withdraw treatment from a patient in a well-resourced urban teaching hospital may navigate the process with relative ease; the same family in a district hospital, or caring for a patient at home, may find the process all but inaccessible. That disparity is difficult to justify on any principled basis, and it is a disparity that only legislation, uniformly applicable across all settings, can credibly address.[32]

Medical Liability and Professional Hesitation: There is also the question of what the current framework does to doctors. A medical professional who participates in the withdrawal of life-sustaining treatment in good faith, following the procedures that courts have prescribed, may nonetheless face persistent uncertainty about their criminal and civil liability. The absence of a statutory safe harbour — a clear legislative provision specifying that compliance with defined criteria confers immunity from prosecution — means that the protection the framework offers is, at best, implicit. The predictable consequence is professional caution: a reluctance to act even in cases where acting is clearly in the patient's best interest, and a corresponding tendency to continue treatment beyond the point at which any therapeutic purpose is served.

The Structural Limits of Judicial Regulation: Finally, and most fundamentally, courts are not regulators. They decide cases; they do not administer systems. The principles the Supreme Court has articulated over the past three decades represent a genuine and important contribution to Indian law. But a framework for end-of-life decision-making cannot be built solely from

[32] See generally Law Comm'n of India, Rep. No. 241, supra note 11, at 28–32 (recommending a statutory regime modelled on the Dutch and Belgian frameworks, with adaptations for the Indian healthcare context).

judicial decisions, each responding to the particular facts of a single case brought by parties with the means and motivation to litigate. What is needed is a framework that can operate prospectively, consistently, and accessibly across every institution and situation in which end-of-life questions arise — a framework that, by definition, only a legislature can provide.[33]

THE CASE FOR LEGISLATIVE REFORM

Comprehensive End-of-Life Legislation: Parliament should enact a statute that codifies the right to die with dignity as recognised by the Supreme Court and establishes a clear, accessible framework for the withdrawal or withholding of life-sustaining treatment. Such legislation would bring uniformity to a domain currently governed by judicial guidelines of varying accessibility, reduce the need for courts to adjudicate what are fundamentally medical and familial decisions, and provide the professional clarity that the current system cannot consistently supply. The statute should be framed as a consolidating measure — one that gives legislative effect to existing constitutional principles rather than seeking to extend or modify them.

Statutory Codification of Procedural Safeguards: The procedural requirements developed in Aruna Shanbaug and Common Cause — medical board assessment, documentation, certification — should be translated into statutory form with modifications designed to make them practicable across different institutional contexts. Statutory codification would give these requirements the force and clarity that judicial guidelines cannot confer, and would provide a consistent benchmark against which practice can be measured and compliance assessed.

Statutory Regulation of Advance Directives: The constitutional recognition given to advance directives in Common Cause should be given statutory effect, with clear provisions governing formal requirements for execution, conditions of validity, procedures for revocation, and the obligations of healthcare providers upon whom a directive is served. A statutory regime for advance directives would give both patients and medical professionals the certainty that the current position, founded solely on judicial pronouncement, cannot reliably supply.

Clarification of Institutional Roles and Medical Liability: Legislation should define, with specificity, the respective roles of clinicians, medical boards, oversight bodies, and courts in end-of-life decision-making. The clinical judgment of qualified medical professionals should

[33] Common Cause (A Registered Society) v. Union of India, (2018) 5 SCC 1, ¶ 241.

be accorded appropriate weight within a statutory framework that provides explicit protection from criminal and civil liability for those who act in compliance with its terms. The role of courts should be reserved for genuine disputes and allegations of abuse, not the routine authorisation of decisions that are properly clinical in character.

An Independent Oversight and Review Mechanism: Legislation should establish an independent oversight body with responsibility for monitoring the exercise of end-of-life decision-making across healthcare institutions. Such a body would review reported cases after the fact, identify systemic issues, make recommendations for the improvement of clinical practice, and refer cases of apparent non-compliance for further investigation. This approach — which mirrors the review committee structures that have operated effectively in comparative jurisdictions — would maintain accountability without requiring prior judicial approval in every case, and would allow clinical decisions to be made in a timely, patient-centred, and legally certain manner.

CONCLUSION

The story of euthanasia law in India is, in one sense, a story of judicial achievement. Faced with legislative silence on one of the most difficult questions that any legal system must address, the Supreme Court has developed — carefully, incrementally, and with evident awareness of the ethical stakes involved — a constitutional framework that takes both the sanctity of life and the demands of human dignity. That framework has given passive euthanasia legal legitimacy, accorded formal recognition to advance directives, and articulated a standard of patient-centred decision-making that reflects the best values of both law and medicine.

In another sense, however, it is a story of institutional limitation. The Court has acknowledged, with increasing directness, that the guidelines it has issued are not a substitute for legislation. They are interim measures — necessary responses to a gap that Parliament has thus far declined to fill. And as Harish Rana (2026) makes clear, that gap has real consequences: for patients cared for outside institutional settings, for doctors uncertain about the legal boundaries of permissible action, and for families struggling to navigate a process whose accessibility depends on where, and by whom, care happens to be provided.

What is required is not a departure from the constitutional principles the Court has established, but their translation into statutory form. Legislation that codifies the right to die with dignity,

establishes clear and accessible procedures, defines the roles of medical professionals and oversight bodies, and provides explicit legal protection for those who act in compliance with its terms would not displace the Court's contribution — it would complete it. The constitutional groundwork has been laid over thirty years of careful judicial reasoning. The time for Parliament to build on it is long overdue.

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