

**EUTHANASIA AND RIGHT TO DIE LEGISLATION: A COMPARATIVE
AND CRITICAL STUDY OF ETHICAL ARGUMENTS, LEGAL
FRAMEWORKS, AND CRITICISM**

- Greeshma D¹ & Sushma K²

ABSTRACT

Euthanasia and right-to-die legislation is a subject of great controversy in modern society. This paper aims to conduct a comparative and critical analysis of the euthanasia issue, including an overview of current international legal practice, with the most detailed attention paid to the Indian context. It distinguishes between euthanasia and assisted suicide and examines the differences between active and passive euthanasia, before exploring trends in the development and spread of legislation on assisted death. The paper provides information on the relevant laws in the Netherlands, Spain, New Zealand, Canada, and, provisionally, France. For India, the main questions include the evolution of the jurisprudence from Gian Kaur to Aruna Shanbaug and Common Cause, through the 2023 judgment and the latest developments in Harish Rana v. Union of India, the arguments for the right to die with dignity based on Article 21, and the restrictions imposed in the form of passive euthanasia.

The paper also explores arguments for legalizing euthanasia, such as autonomy, dignity, and relief from suffering, as well as concerns against legalization, such as the slippery slope, disability rights, religious beliefs, the role of physicians, and the availability of palliative care. Particular focus is placed on Canada's Medical Assistance in Dying program, which has been formally condemned by the United Nations and now faces the threat of being declared unconstitutional. Thus, this paper conducts a critical analysis of the euthanasia issue, considering

¹ Student, BBA LLB (Hons), St Aloysius School of Law, Mangaluru.

² Assistant Professor of Law, St Aloysius School of Law, Mangaluru.

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both sides of the debate. However, the discussion focuses on addressing concerns and issues related to the practical aspects of implementing euthanasia, rather than the principle of autonomy itself.

1. INTRODUCTION

The question of whether, and under what conditions, a person should be permitted to receive medical assistance in ending their own life sits at the intersection of individual liberty, medical ethics, disability justice, and constitutional interpretation. Over the past three decades, the number of jurisdictions permitting some form of euthanasia or assisted suicide has grown from a single country to more than a dozen nations and a substantial number of subnational jurisdictions.³ This expansion has been accompanied by an equally significant body of criticism, much of it emerging not only from traditional religious and conservative sources but increasingly from disabilityrights advocates, palliativecare physicians, and international humanrights bodies who argue that legal frameworks intended to protect autonomy can, in practice, expose vulnerable persons to pressures that have little to do with genuinely free choice.

India occupies a distinctive position in this global landscape. Unlike jurisdictions that have enacted comprehensive assisted-dying statutes through their legislatures, India's right to die with dignity has emerged almost entirely through constitutional adjudication, culminating in the Supreme Court's recognition of passive euthanasia and advance medical directives as facets of the right to life under Article 21 of the Constitution.⁴ This judicially crafted framework recently simplified in 2023 and further clarified in 2026 offers a valuable comparative case study precisely because it demonstrates how a right can be recognised in principle while remaining constrained, and contested, in practice.

This paper does not attempt to adjudicate the underlying moral question of whether assisted dying is right or wrong. Rather, it maps the terrain: it summarises the legal status of euthanasia and assisted suicide internationally and in India, presents the principal arguments advanced by proponents, and gives sustained attention to the criticisms that

³LegalClarity, 'Countries Where Euthanasia is Legal and Who Qualifies' (2026) <<https://legalclarity.org/>> accessed September 2026.

⁴ Constitution of India 1950, art 21.

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have accumulated around existing legislation, drawing on Canada's Medical Assistance in Dying programme as a detailed case study of how a permissive and rapidly expanding framework has attracted international scrutiny even from bodies generally sympathetic to expanded individual rights.

2. DEFINITIONS AND CONCEPTUAL DISTINCTIONS

Precision in terminology matters because different legal regimes permit different practices, and much public debate conflates them. Euthanasia: a physician or other clinician directly administers a lethal substance to the patient at the patient's request. Assisted suicide or physician-assisted death: a clinician prescribes a lethal substance that the patient self-administers. Voluntary, non-voluntary, and involuntary: voluntary euthanasia occurs at the competent patient's request; non-voluntary occurs when the patient cannot express a preference; involuntary occurs against the patient's wishes and is universally treated as unlawful killing. Passive euthanasia: withdrawing or withholding life-sustaining treatment to allow death to occur naturally. This is legally distinct from active euthanasia in most jurisdictions. India is one such jurisdiction: it permits withdrawal or withholding of life-sustaining treatment under strict judicial oversight where active euthanasia remains a criminal offence.⁵

A right to die legislation generally permits one or more of these acts within a set of procedural safeguards, for example, waiting periods, independent medical consultations, and formal capacity assessments. As will be discussed below, India only allows the last of these four categories, and that too through a judicially administered process rather than an isolated parliamentary statute.

3. THE GLOBAL LEGAL LANDSCAPE

The Netherlands was the first country to legalize euthanasia and assisted suicide on a national level within a defined legal framework. According to the Termination of Life on Request and Assisted Suicide Act, which began operating in the country in 2002,

⁵ World Population Review, 'Countries Where Euthanasia is Legal 2026' <<https://worldpopulationreview.com/>> accessed September 2026.

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euthanasia is not decriminalized; instead, doctors who perform it are exempt from punishment if six due care requirements are met.⁶

Belgium's Act on Euthanasia entered into force in September 2002, the same year as the Dutch law, and was later extended to competent minors in 2014.⁷ Switzerland has not punished assisted suicide since 1942 under a criminalcode provision that prohibits only assistance motivated by self-interest, a framework that has made the country a destination for foreign nationals seeking assisted death.⁸

In Canada, medical assistance in dying was legalized in 2016 for patients with a natural death that could be foreseen and, after the Quebec Superior Court ruling in Truchon, the law was amended in 2021 to include a second track for patients who suffer from a grievous and irremediable condition and whose death is not reasonably foreseeable.⁹ In the United States, physicianassisted death remains distinct from euthanasia: Oregon's Death with Dignity Act, passed in 1997, established a model a terminal diagnosis with a life expectancy of six months or less, confirmed by two physicians that a growing number of states have since adopted, while euthanasia remains unlawful throughout the country.¹⁰ Australia rolled out voluntary assisted dying on a statebystate basis beginning with Victoria in 2017, reaching all six states by 2023, while Spain, New Zealand, Colombia, Ecuador, Uruguay, and Austria have each enacted some form of euthanasia or assistedsuicide law within the past several years.¹¹¹²¹³

In July 2026, France's National Assembly approved legislation permitting assisteddying, a step that pending further legislative and judicial process would bring France into a

⁶ Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 (Netherlands); LegalClarity (n 1).

⁷ Act on Euthanasia 2002 (Belgium), as amended in 2014 to extend eligibility to competent minors; LegalClarity (n 1).

⁸ Swiss Criminal Code 1937, art 115; Time (n 2).

⁹ Criminal Code of Canada, as amended by SC 2016, c 3 and SC 2021, c 2 (Bill C -7); Canadian Affairs, 'MAID Increases Ottawa Holds Firm' (5 December 2025) <<https://www.canadianaffairs.news/>> accessed September 2026.

¹⁰ Oregon Death with Dignity Act, Or Rev Stat §§ 127.800–127.897 (1997); Time (n 2).

¹¹ LegalClarity, 'Countries Where Euthanasia Is Legal and Who Can Apply' (2026) <<https://legalclarity.org/>> accessed September 2026.

¹² Organic Law 3/2021 of 24 March, regulating euthanasia (Spain); LegalClarity (n 9).

¹³ End of Life Choice Act 2019 (New Zealand), approved by binding referendum in 2020 and in force from 2021; Dignity in Dying, 'Assisted Dying Around the World' (27 July 2026) <<https://www.dignityindying.org.uk/>> accessed September 2026.

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growing bloc of roughly ten European countries with some form of legal assisted dying.¹⁴ On the other hand, the United Kingdom continues to criminalize assisted suicide, although legislation has been passed in Parliament and is currently being considered. Most recently, however, MPs voted against a new initiative to legalize it in September 2026,¹⁵ and several proposals elsewhere, such as Slovenia's 2025 assisted dying law, have been rejected at the ballot box or in subsequent votes.¹⁶

Table 1 summarises the core features of several representative jurisdictions, including India, whose framework is examined in detail in the section that follows.

Jurisdiction	Practice Permitted	Year	Core Eligibility
Netherlands	Euthanasia & assisted suicide	2002	Unbearable suffering, no prospect of improvement; six due-care criteria
Belgium	Euthanasia	2002	Constant, unbearable suffering; extended to minors in 2014
Switzerland	Assisted suicide only	1942	Lawful absent a self-interested motive; open to non-residents
Canada	Medical Assistance in Dying	2016; expanded 2021	Track 1 (foreseeable death) and Track 2 (grievous, irremediable, not foreseeable)
United States	Physician-assisted	Oregon 1994;	Terminal diagnosis, six-

¹⁴ Bill establishing a right to medical aid in dying, approved by the French National Assembly, 15 July 2026; Time (n 2).

¹⁵ Suicide Act 1961 (UK), s 2; Time (n 2).

¹⁶ Euronews, 'Slovenia Rejects Assisted Dying Law for Terminally Ill Patients' (24 November 2025) <<https://www.euronews.com/>> accessed September 2026.

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(select states)	death (self-administered)	extended since	month prognosis; euthanasia unlawful
Australia	Voluntary assisted dying	Victoria 2017	Terminal illness, limited life expectancy; state-regulated
Spain	Euthanasia & assisted suicide	2021	Serious incurable/chronic-debilitating condition; intolerable suffering

4. THE INDIAN LEGAL FRAMEWORK

India has not enacted a dedicated euthanasia or assisted-dying statute. Instead, the right to die with dignity has been developed gradually by the Supreme Court through interpretation of Article 21 of the Constitution, which guarantees that no person shall be deprived of their life or personal liberty except according to procedure established by law.¹⁵ The resulting framework permits passive euthanasia in narrowly defined circumstances but continues to prohibit both active euthanasia and physician-assisted suicide.

4.1.FROM P. RATHINAM TO GIAN KAUR

The Supreme Court's engagement with the right to die began indirectly, through challenges to the criminalisation of attempted suicide. In *P. Rathinam v Union of India*, a two-judge bench held that the right to life under Article 21 included a right not to live a forced life, and accordingly struck down Section 309 of the Indian Penal Code, which criminalised attempted suicide, as unconstitutional.¹⁷¹⁸ This position proved short-lived. In *Gian Kaur v State of Punjab*, a five-judge Constitution Bench overruled *Rathinam*, holding that the right to life could not logically be read to include its own extinction, and

¹⁷ *P Rathinam v Union of India*, (1994) 3 SCC 394.

¹⁸ Indian Penal Code 1860, s 309.

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that Section 309 was therefore not unconstitutional on that basis.¹⁹ Significantly, however, the Court in *Gian Kaur* also observed, in obiter, that the right to live with dignity could be understood to include a right to die with dignity in the context of a person who is already in the process of dying language that later decisions would draw upon to develop the passive-euthanasia jurisprudence discussed below, The Court in *Gian Kaur* did see that the “right to live with dignity” may also entail a “right to die with dignity” in the context of a person already in the process of dying. This obiter was the bedrock of subsequent passive-euthanasia jurisprudence, most notably in *Common Cause v. Union of India* (2018).

4.2.ARUNA SHANBAUG AND THE RECOGNITION OF PASSIVE EUTHANASIA

The Court’s next major intervention arose from the tragic case of Aruna Ramchandra Shanbaug, a nurse who had remained in a persistent vegetative state for decades following a violent assault. In *Aruna Ramchandra Shanbaug v Union of India*, the Supreme Court dismissed the specific plea to withdraw her life support, finding that the hospital staff who had cared for her for years did not support withdrawal, but the Court simultaneously legalised passive euthanasia in principle for the country as a whole, subject to a mandatory requirement of High Court approval in each individual case.²⁰ Commentators have since described this outcome as conceptually significant but procedurally unworkable: while the judgment established that withdrawal of life support could be lawful, the requirement of case-by-case High Court sanction made the remedy largely inaccessible to ordinary patients and families.²¹

4.3.COMMON CAUSE (2018): ADVANCE DIRECTIVES AND THE RIGHT TO DIE WITH DIGNITY

The procedural gap left open by *Aruna Shanbaug* was substantially addressed in *Common Cause (A Regd Society) v Union of India*, in which a five-judge Constitution Bench held

¹⁹ *Gian Kaur v State of Punjab*, (1996) 2 SCC 648.

²⁰ *Aruna Ramchandra Shanbaug v Union of India*, (2011) 4 SCC 454.

²¹ Ranjit I James and others, ‘Common Cause (A Regd Society) v Union of India [2018] INSC 223: EndofLife Care in India’ (2025) SAGE Journals <<https://journals.sagepub.com/>> accessed September 2026.

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that the right to die with dignity is itself a fundamental right under Article 21, and laid down a detailed framework permitting individuals to execute advance medical directives commonly termed ‘living wills’ instructing physicians to withhold or withdraw life-sustaining treatment in the event the person later becomes unable to communicate their wishes.²² The 2018 guidelines required that an advance directive be executed before a Judicial Magistrate of First Class at the stage of execution and be given effect only after clearance by both a treating-hospital Medical Board and an independent Medical Board constituted by the relevant District Collector, in addition to the Judicial Magistrate’s own countersignature before life support could be withdrawn.²²

As with Aruna Shanbaug before it, the 2018 guidelines proved procedurally cumbersome. Commentators and medical professional bodies observed that the multi-layered requirement of judicial oversight and sequential clearance by two medical boards (a treating-hospital board followed by an independent board constituted by the District Collector) created delays that defeated the very purpose of an advance directive, particularly in time-sensitive intensive-care settings.²³

4.4.THE 2023 MODIFICATION AND SIMPLIFIED PROCEDURE

In January 2023, a five-judge Constitution Bench, acting on a miscellaneous application filed by the Indian Society of Critical Care Medicine, modified the 2018 guidelines to ease the process of executing and giving effect to advance directives.²³ The Court held that the earlier directions had proved unworkable in practice and required deletion and replacement rather than a full review of the underlying judgment.²⁵ Under the revised procedure, an advance directive must be executed in writing, signed in the presence of two witnesses, and attested by a Notary or a Gazetted Officer; the earlier requirement of countersignature by a Judicial Magistrate of First Class was removed entirely.²⁴ A

²² Common Cause (A Regd Society) v Union of India, (2018) 5 SCC 1.

²³ Common Cause (A Regd Society) v Union of India, 2023 SCC OnLine SC 99 (order dated 24 January 2023).²⁵Supreme Court Observer, ‘Supreme Court Review 2023: Right to Life’ (29 December 2023) <<https://www.scobserver.in/>> accessed September 2026.

²⁴ Luke & Luka, ‘Common Cause v Union of India (2018) — India’s Living Will Judgment’ (26 May 2026)

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treating-hospital Medical Board and Hospital Ethics Committee remain responsible for verifying, at the relevant time, that the conditions specified in the directive have been met before treatment is withdrawn or withheld, but the layered judicial-cum-medical clearance of the original framework was substantially streamlined.²⁷ The Bench also observed that the legislature, rather than the judiciary, was better placed to enact a comprehensive statutory framework for endoflife care, given the medical and administrative expertise such legislation would require, though Parliament has yet to enact such a law.²⁵

4.5.HARISH RANA V UNION OF INDIA (2026): CLARIFYING THE SCOPE OF PASSIVE EUTHANASIA

The most recent significant development is Harish Rana v Union of India, decided by the Supreme Court in March 2026, which addressed whether clinically assisted nutrition and hydration administered through nasogastric or PEG feeding tubes constitutes ‘medical treatment’ that may be withdrawn under the Common Cause framework, or whether it instead amounts to basic nursing care that must always be continued. The Court held that such nutritional support is a form of medical treatment requiring clinical assessment and ongoing management, and therefore falls within the passive euthanasia framework: it may lawfully be withdrawn where it no longer serves a therapeutic purpose and merely prolongs biological existence in a permanently vegetative state.²⁶ This ruling cleared a great deal of ambiguity that had existed since Aruna Shanbaug about whether clinically assisted nutrition and hydration is ‘medical treatment’ which could be withdrawn or ‘basic care’ which had to always continue. It shows that the Indian right to die jurisprudence keeps on slowly evolving rather than changing by way of exhaustive legislation.

<<https://lukeandluka.in/>> accessed September 2026, summarising the 2023 modification requiring attestation by a Notary or Gazetted Officer in the presence of two witnesses in place of countersignature by a Judicial Magistrate of First Class.

²⁵ Mental Healthcare Act 2017, s 115(1).

²⁶ Harish Rana v Union of India (Supreme Court of India, 11 March 2026), Pardiwala and Viswanathan JJ; see also entry summarising the decision at ‘Harish Rana v. Union of India’

<https://en.wikipedia.org/wiki/Harish_Rana_v._Union_of_India> accessed September 2026.

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4.6.DECRIMINALISATION OF ATTEMPTED SUICIDE AND THE LIMITS OF THE INDIAN FRAMEWORK

A related but conceptually distinct development is the decriminalisation of attempted suicide under Section 115 of the Mental Healthcare Act, 2017, which presumes a person who attempts suicide to have been under severe stress, bars trial or punishment under the Indian Penal Code, and entitles them to care, treatment, and rehabilitation from the appropriate government. This effectively restricted Section 309 of the IPC. With the IPC's replacement by the Bharatiya Nyaya Sanhita, 2023, attempted suicide is now fully decriminalised, except for Section 224 (attempts intended to coerce a public servant). Indian courts have since held that this statutory presumption effectively precludes prosecution under Section 309 in the ordinary run of cases, with one High Court describing the continuance of Section 309 as 'an anachronism unworthy of a human society like ours.'²⁷ It is important to note, however, that this decriminalisation addresses suicide generally and does not itself authorise assisted suicide or active euthanasia, both of which remain criminal offences in India. The Law Commission of India has, on more than one occasion, recommended statutory clarity on the withholding and withdrawal of treatment for terminally ill patients, but no comprehensive parliamentary legislation has yet followed the Supreme Court's constitutional pronouncements.²⁸ India's framework therefore remains narrower than those of the Netherlands, Belgium, Canada, or Spain: it permits passive euthanasia through a regulated advance-directive procedure, but continues to prohibit both physician-assisted suicide and active euthanasia in all circumstances.

5. ARGUMENTS ADVANCED IN SUPPORT OF LEGISLATION

5.1.AUTONOMY AND SELF-DETERMINATION

²⁷ State v Sanjay Kumar Bhatia, Delhi High Court, cited in Lakshmi Vijayakumar and others, 'Practical Implications of Mental Healthcare Act 2017: Suicide and Suicide Attempt' (2019) PMC

<<https://pmc.ncbi.nlm.nih.gov/articles/PMC6482674/>> accessed September 2026.

²⁸ Law Commission of India, 'Passive Euthanasia — A Relook' (Report No 241, 2012); Law Commission of India, 'Medical Treatment of Terminally Ill Patients (for the Protection of Patients and Medical Practitioners)' (Report No 196, 2006).

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The most commonly cited argument for legalising euthanasia and assisted dying is respect for personal autonomy: the principle that competent adults have the right to make fundamental decisions about their own bodies and the manner and timing of their death, particularly when facing terminal or irremediable suffering. Proponents argue that this follows logically from rights already well established in most legal systems, including the right to refuse lifesustaining treatment a right the Indian Supreme Court itself grounded in Article 21 in both Aruna Shanbaug and Common Cause.

5.2.RELIEF OF SUFFERING AND DIGNITY

A second argument centres on the relief of physical and existential suffering that cannot always be fully addressed even by high-quality palliative care. Advocates argue that for a subset of patients, pain, breathlessness, loss of bodily control, or a sense of indignity persist despite optimal symptom management, and that the state has no compelling interest in prolonging that suffering against the patient's wishes. The Indian courts have repeatedly used the language of 'dying with dignity' to frame this interest as a facet of the broader constitutional guarantee of a dignified life, where dignity is understood as protecting the patient from an existence reduced to mere biological survival without awareness or personhood.

5.3.CONSISTENCY AND REGULATORY TRANSPARENCY

Supporters also argue that legal, regulated frameworks bring a previously clandestine practice into the open, replacing informal and unregulated hastening of death which some advocates contend occurs, though the court grounded its rationale in filling a legislative vacuum rather than regulating an acknowledged practice. On this view, legalisation is less a departure from existing practice than an attempt to govern it, an argument that also underlay the Supreme Court's rationale in Common Cause for replacing ad hoc, unregulated withdrawal decisions with a documented advancedirective procedure.

6. CRITICISMS AND CONCERNS

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Critics of euthanasia and right-to-die legislation raise objections spanning religious, philosophical, medical, and social-justice grounds. The sections below address the most prominent and well documented of these criticisms.

6.1.THE SLIPPERY SLOPE ARGUMENT

Critics frequently argue that initially narrow eligibility criteria tend to expand over time, a pattern they point to in several jurisdictions. Belgium's extension of euthanasia to minors in 2014, and Canada's 2021 expansion from patients with a reasonably foreseeable death to patients whose death is not foreseeable, are commonly cited as evidence that critics point to a pattern where initially restrictive eligibility criteria are subsequently expanded through legal challenges or legislative amendments.³³³⁴ Even in India, where the substantive right remains confined to passive euthanasia, the progression from a plea concerning a single patient in Aruna Shanbaug to a generally applicable advance-directive regime in Common Cause, followed by a procedural simplification in 2023, illustrates a comparable if more incremental and judicially supervised pattern of gradual expansion, though in India the expansion has been primarily procedural and doctrinal, with only modest definitional broadening of the qualifying medical categories. Proponents counter that expansion reflects considered legislative or judicial responses to specific claims of unjust exclusion rather than an uncontrolled drift, but the empirical pattern of eligibility broadening is not seriously disputed by either side.

6.2.THE DISABILITY-RIGHTS CRITIQUE

Perhaps the most sustained and well-documented criticism in recent years has come from disability-rights organisations, who argue that assisted-dying frameworks can encode ableist assumptions namely, that a life with significant disability is inherently less worth living, or that suffering rooted in social and economic deprivation can be legitimately resolved through death rather than through improved support. In Canada, a coalition of disability-rights organisations, including the Council of Canadians with Disabilities and Inclusion Canada, filed a Charter challenge against MAID's Track 2 provisions, arguing that the law has led to premature deaths among people who sought assistance in dying

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because they lacked adequate housing, income support, or care rather than because their medical condition itself was unbearable.²⁹³⁰

This concern is reinforced by demographic context: the proportion of Canadians aged fifteen and older reporting a disability rose from twenty-two per cent in 2017 to twenty-seven per cent in 2022, alongside documented and rising rates of poverty and housing insecurity within that population.³⁷³⁸ Advocacy groups and researchers have compiled case narratives including a widely reported case involving a woman with multiple chemical sensitivity who sought MAID after being unable to secure affordable, adequately ventilated housing that they present as evidence that some individuals access assisted death as a substitute for social supports they were unable to obtain.³¹

In March 2025, the United Nations Committee on the Rights of Persons with Disabilities formally reviewed Canada's implementation of the Convention on the Rights of Persons with Disabilities and expressed concern that Canada's approach to MAID emphasises individual autonomy without sufficient safeguards to protect people with disabilities, recommending that Canada repeal Track 2 eligibility and pause further expansion.³² Canadian federal officials have stated they do not intend to reverse Track 2 eligibility.³³ Survey research reflects a genuinely divided public on this point: polling by the Angus Reid Institute found that while a large majority of Canadians (seventy-six per cent) support MAID in principle, a similar majority (sixty-two per cent) reported concern that socially and financially vulnerable people might seek MAID because adequate care and

²⁹ Global News, 'Health Matters: Disability Rights Coalition Speaks Out Against MAiD Laws' (27 September 2024) <<https://globalnews.ca/>> accessed September 2026.

³⁰ The Conversation, 'Disability Rights are Shaped by the Narratives Embedded in Policies Like the Accessible Canada Act and MAID' (20 January 2026) <<https://theconversation.com/>> accessed September 2026.³⁸ Canadian Journal of Bioethics, 'Why Track 2 MAiD is Discriminatory' (3 November 2025) <<https://www.cjb-rcb.ca/>> accessed September 2026.

³¹ Breach Media, 'Canada Sidesteps UN Scrutiny Over Assisted Dying' (11 February 2026) <<https://breachmedia.ca/>> accessed September 2026.

³² UN Committee on the Rights of Persons with Disabilities, Concluding Observations on the Combined Second and Third Periodic Reports of Canada, UN Doc CRPD/C/CAN/CO/2-3 (21 March 2025); Canadian Affairs, 'Op-Ed: UN Committee Rightly Calls Out Canada's Systemic Devaluation of Disability' (8 June 2025) <<https://www.canadianaffairs.news/>> accessed September 2026.

³³ Canadian Affairs (n 7).

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support are unavailable to them, suggesting that support for the underlying right and concern about its practical implementation are not mutually exclusive positions.³⁴

6.3.SANCTITY OF LIFE AND RELIGIOUS OBJECTIONS

Many religious traditions hold that human life has intrinsic value that is not contingent on quality of life, capacity, or suffering, and that deliberately ending a life even at the person's own request violates a moral or religious prohibition on taking human life. This objection is foundational to opposition from the Catholic Church and numerous other religious communities, and it has shaped legislative debate and referendum outcomes in numerous jurisdictions, including the 2025 rejection of an assisted dying proposal in Slovenia.⁴³ In India, similar sanctity-of-life reasoning informed the Supreme Court's initial reluctance, in *Gian Kaur*, to read a general right to die into Article 21, even as the Court later carved out a narrower dignity-based exception for the passive withdrawal of treatment from the terminally ill.

6.4.THE PHYSICIAN'S ROLE AND MEDICAL ETHICS

A related but distinct objection concerns the role asked of physicians. Critics, including some physician associations, argue that a clinical mandate to preserve life is fundamentally in tension with a clinical role in ending it, and that normalising physician participation in hastening death risks eroding patient trust, particularly among populations including disabled people and elderly patients who may already have reason to distrust medical judgments about the value of their lives. India's reliance on institutional Medical Boards and Hospital Ethics Committees, rather than a single treating physician's discretion, reflects an attempt to distribute this responsibility and mitigate the risk of individual clinical bias, though critics note that committee-based decision-making can itself introduce delay and inconsistency across institutions.

6.5.ADEQUACY OF PALLIATIVE CARE AND GENUINE ALTERNATIVES

³⁴ Angus Reid Institute, 'Disability & MAID: Three in Five Concerned Lack of Adequate Care May Push Vulnerable to Consider Assisted Dying' (25 May 2026) <<https://angusreid.org/>> accessed September 2026.

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Critics argue that a genuine choice between life and assisted death requires that palliative care, pain management, mental-health support, and social services be robust and universally accessible; where such support is inconsistent or unavailable, the ‘choice’ to die is argued to be constrained rather than free. This argument featured prominently in the Canadian disability-rights critique above, where advocates contend that MAID has, in some documented cases, become available more quickly and reliably than the housing, home care, or disability supports that might have addressed the underlying suffering.³⁵ The concern applies with particular force in India, where palliative-care infrastructure remains unevenly distributed between urban and rural areas; critics of any future expansion beyond passive euthanasia argue that meaningful choice cannot be said to exist until palliative and hospice care are reliably accessible nationwide, a concern the Law Commission itself flagged in recommending that statutory reform proceed alongside investment in palliative infrastructure.⁴⁵

6.6.SAFEGUARD DESIGN AND INSTITUTIONAL OVERSIGHT

Finally, critics scrutinise the practical adequacy of procedural safeguards waiting periods, independent assessments, capacity evaluations, and reporting requirements arguing that oversight mechanisms in several jurisdictions rely heavily on self-reporting by the same clinicians who approve and provide the procedure, with limited independent, prospective review. India’s post-2023 procedure, which replaced judicial countersignature with notarial or gazetted-officer attestation, illustrates the underlying policy tension directly: simplifying procedure to make a right meaningfully accessible necessarily reduces the number of independent checks involved in each decision, and reasonable observers can disagree about where the balance between accessibility and oversight should be struck. Proponents of stronger safeguards argue that better data collection and independent case review, rather than abolition, are the appropriate response, while more categorical critics argue that no set of procedural safeguards can fully eliminate the risk of subtle coercion or unmet need masquerading as autonomous choice.

³⁵ Accessible Housing Calgary, ‘When Support Fails: The Deepening Crisis Behind Track 2 of MAiD for People with Disabilities’ (28 May 2025) <<https://accessiblehousing.ca/>> accessed September 2026.

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7. CASE STUDY: CANADA'S MEDICAL ASSISTANCE IN DYING PROGRAMME

Canada's experience is instructive precisely because MAID is among the most permissive and fastest-growing assisted-dying frameworks in the world, making its documented controversies a useful comparative lens for jurisdictions such as India that are contemplating whether and how far to extend the right beyond passive euthanasia. Health Canada's most recent annual reporting recorded 16,499 MAID deaths in 2024, accounting for approximately five per cent of all deaths in the country that year, following 15,343 deaths in 2023 a roughly sixteen per cent year-over-year increase, and part of a sustained average annual growth rate of approximately thirty-one per cent between 2019 and 2022.⁴⁶³⁶ The large majority of cases approximately ninety-six per cent in 2024 involved patients whose natural death was reasonably foreseeable under Track 1; the remainder involved Track 2 cases, where death was not foreseeable, which is the category that has drawn the most sustained human-rights scrutiny.⁴⁸

The Canadian case illustrates the paper's central tension in sharp relief. On one hand, the programme reflects a legislature and judiciary responding to autonomy-based claims that a narrower law unjustly excluded suffering patients. On the other, it has generated a formal United Nations finding that the law's safeguards are inadequate to protect people with disabilities from the risk that unmet social and economic needs rather than the underlying medical condition are driving some requests for assisted death.⁴⁹ Both empirical claims rising uptake and rising documented concern are well supported in the available data, and the Canadian experience suggests that expanding eligibility and protecting vulnerable populations are not automatically compatible without significant, sustained investment in the social and medical supports that make death one option among genuine others rather than the most readily available one. For India, where the judicially crafted framework remains confined to passive euthanasia, the Canadian experience offers a cautionary comparative data point should future legislative reform contemplate any expansion toward active euthanasia or assisted suicide.

8. POLICY CONSIDERATIONS

³⁶ Canadian Affairs, 'Op -Ed' (n 34).

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Across jurisdictions, several recurring policy design questions shape how the tension between autonomy and protection is managed in practice: Eligibility scope: whether eligibility is limited to terminal illness with a defined prognosis, or extended to non-terminal grievous and irremediable conditions, including, in some proposals, mental illness alone. Independent assessment: the number and independence of clinicians or bodies required to confirm eligibility, and whether assessors possess relevant specialty expertise in disability, palliative care, or psychiatry. Waiting periods and reflection time: mandatory intervals between request and provision, intended to distinguish durable from transient wishes. Access to alternatives: whether law or policy requires that palliative care, disability supports, or mental-health treatment be offered and reasonably accessible before or alongside an assisted-dying request. Independent oversight and data collection: whether review of individual cases occurs prospectively or only through retrospective, aggregate reporting, and whether reviewers are independent of the treating clinicians. These design choices, rather than the underlying yes-or-no question of legalisation, are where much of the substantive policy disagreement between otherwise sympathetic stakeholders including some disability rights advocates who do not oppose assisted dying in principle but object to specific implementations actually occurs. For India specifically, the central open policy question remains whether Parliament will enact comprehensive legislation at all a step the Supreme Court has now characterized not as institutional preference but as constitutional necessity and if so, whether such legislation will codify the passive-euthanasia framework as it stands or reopen the more contested question of active euthanasia or assisted suicide.

9. RESEARCH GAP IN EUTHANASIA AND RIGHT TO DIE LEGISLATION

Despite the rapid global expansion of euthanasia and assisted-dying legislation over the past three decades, empirical research has not kept pace with the normative and doctrinal literature on the subject.³⁷ Most existing scholarship including comparative legal analyses

³⁷ Fifty Years of Empirical Research on Medical Assistance in Dying: A Mapping Review (2024) <https://pubmed.ncbi.nlm.nih.gov/42659870/> accessed September 2026.

³⁶ 'Comparison of Official Reporting on Assisted Suicide and Euthanasia Across Jurisdictions' (2022) <https://pubmed.ncbi.nlm.nih.gov/36585221/> accessed September 2026.

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like this one focuses on whether a right to die exists and how courts or legislatures have framed it, but far less work examines the lived consequences of these frameworks once enacted.

Absence of longitudinal, cross-jurisdictional outcome data. While individual countries publish annual statistics on assisted-dying uptake, there is no standardised, comparative dataset tracking outcomes across jurisdictions, since official reports vary so significantly in the measures they collect that meaningful cross-jurisdictional comparison is currently obstructed.³⁶ A recent mapping review of fifty years of empirical research on medical assistance in dying similarly concludes that the field's methods have not diversified enough to support standardised outcome reporting or reliable comparability across jurisdictions.³⁷

Under-researched link between socioeconomic deprivation and assisted-dying requests. Disability-rights advocates argue that unmet social needs, rather than unbearable medical suffering, may drive some requests, but rigorous empirical work isolating this causal relationship as opposed to case narratives and advocacy reporting remains scarce.³⁸

Insufficient evaluation of safeguard design against real-world outcomes. Peer-consultation and independent-review requirements are near-universal procedural safeguards, yet they remain comparatively under-researched, with studies noting that physicians are not always legally obliged to adhere to consultation outcomes even where such review exists.³⁹

Neglect of the post-legalisation palliative care relationship. Whether the introduction of assisted-dying legislation correlates with increased or decreased investment in palliative infrastructure over time remains an open empirical question not addressed by the existing literature reviewed above.

10. CONCLUSION

37Fifty Years of Empirical Research on Medical Assistance in Dying (n 1).

38Accessible Housing Calgary (n 33); Angus Reid Institute (n 32).

39Stijn Vissers and others, 'Characteristics and Outcomes of Peer Consultations for Assisted Dying Request Assessments: Cross-Sectional Survey Study Among Attending Physicians' (2023) *Frontiers in Public Health* <https://www.frontiersin.org/journals/public-health/articles/10.3389/fpubh.2023.1100353/full> accessed September 2026.

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Euthanasia and right to die legislation has expanded significantly over the past decade, driven substantially by autonomy-based and dignity-based arguments that have proven persuasive to courts, legislatures, and, in several countries, voters directly. At the same time, that expansion has generated an increasingly well-documented body of criticism, most notably from disability rights advocates and international human-rights bodies, centred not on a rejection of individual choice as such but on the concern that choice exercised amid inadequate social, economic, and medical support may not be the free choice the law presumes it to be.

India's experience offers a distinctive comparative perspective: through a sequence of Constitution Bench decisions spanning three decades – from Gian Kaur's cautious refusal to read a general right to die into Article 21, through Aruna Shanbaug's procedurally cumbersome recognition of passive euthanasia, to Common Cause's advance-directive framework and its 2023 simplification, and most recently Harish Rana's clarification of what counts as withdrawable medical treatment – the Indian judiciary has built a right to die with dignity incrementally and cautiously, while consistently declining to extend that right to active euthanasia or assisted suicide, and repeatedly inviting Parliament to legislate comprehensively. The Canadian case, by contrast, demonstrates that even a comparatively permissive and rapidly expanding legislative framework can generate rapid programmatic growth, formal United Nations criticism, and a still-pending domestic Charter challenge within a single jurisdiction generally regarded as having one of the world's most developed assisted-dying frameworks.

Future policy debate, in India and elsewhere, is likely to turn less on whether a right to die with dignity should exist in principle – a question on which many societies, India included, have already reached a provisional answer – and more on the harder, more granular question of what safeguards, what access to genuine alternatives, and what independent oversight are sufficient to ensure that the choice being protected is, in fact, free. This asymmetry is a part of the Indian position. For three decades the Supreme Court proceedings have been characterized, as temporary measures till the time a comprehensive law is passed by the Parliament. However, till date, the Parliament has not taken up the issue of passing any law in relation to the practice of euthanasia. Hence,

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though detailed, the solution is fragile. It does not provide an efficient mechanism and does not take into consideration the needs of various High Courts and hospitals having diverse infrastructure. In fact, in some of the other countries where legislation has taken place, the debate has shifted from the issue of the existence of the right to the mechanism of its implementation. The judicial review would not be sufficient to deal with such issues. Further, the expansion of the scope of the right in Canada, from the right to die in the case of an incurable disease to the right to die in the case of grievous bodily harm and the subsequent debate regarding the inclusion of mental illnesses as a sole underlying illness reflects the inadequacy of the language of the law to respond to the issues of moral hazards that it seeks to address. Thus, even though India's judicial restraint has kept away such mission creep; it has also denied the patients, families and doctors the ability to take such decisions with clarity. Therefore, the larger issue is that of identifying the right as a whole. It needs to be seen whether India's position reflects wisdom or lack of will to address this complex but important issue. The issues need to be addressed by the Parliament while taking into consideration the various aspects of the issue, viz., the availability of resources, the infrastructure, the resources and the training of the personnel along with issues of compensation.

LEGISLATION AND CONSTITUTIONAL PROVISIONS

1. Constitution of India 1950, art 21.
2. Indian Penal Code 1860, s 309.
3. Mental Healthcare Act 2017, s 115.
4. Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 (Netherlands).
5. Act on Euthanasia 2002 (Belgium).
6. Swiss Criminal Code 1937, art 115.
7. Criminal Code of Canada, as amended by SC 2016, c 3 and SC 2021, c 2.
8. Oregon Death with Dignity Act, Or Rev Stat §§ 127.800–127.897 (1997).
9. Organic Law 3/2021 of 24 March, regulating euthanasia (Spain).
10. End of Life Choice Act 2019 (New Zealand).

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11. Suicide Act 1961 (UK).

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1. P Rathinam v Union of India, (1994) 3 SCC 394.
2. Gian Kaur v State of Punjab, (1996) 2 SCC 648.
3. Aruna Ramchandra Shanbaug v Union of India, (2011) 4 SCC 454.
4. Common Cause (A Regd Society) v Union of India, (2018) 5 SCC 1.
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