Sortuz. Oñati Journal of Emergent Socio-legal Studies
Volume 15, Issue 2 (2025), 503-530
ISSN 1988-0847
DOI link: https://doi.org/10.35295/sz.iisl.2379

Reframing End-of-Life Jurisprudence: Legal Contours, Bioethical Tensions, and the Evolving Right to Die with Dignity in India

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Abstract:

This paper reflects on the changing legal, ethical, and cultural dimensions of euthanasia, especially passive euthanasia as envisaged by Article 21 of the Constitution of India. The paper maps out the crucial legal landmarks—from *Gian Kaur v. State of Punjab* (1996) to *Aruna Shanbaug v. Union of India* (2011) and *Common Cause v. Union of India* (2018), signalling the transition in judicial jurisprudence, wherein the right to die with dignity has been increasingly acknowledged. It examines the conceptual contradictions between autonomy and the sanctity of life from a global bioethical perspective, contextualizing the Indian experiences. Even with judicial progress, the practice of passive euthanasia is throttled by procedural hypotrophy, institutional intransigence, and societal equivocation. The paper also raises questions about the utility of living wills, the constraints of the 2024 decision of the Delhi High Court, and the existing legislative vacuum. It makes the case for a right-based, culturally competent, and legislatively sound approach to end-of-life care that respects human dignity and ethical responsibility. Finally, it demands a transition from judicial tolerance to systemic readiness and argues for law reform's human and social desirability.

Keywords:

Passive euthanasia, right to die with dignity, end-of-life jurisprudence, bioethics in India, advance directives (living will).

I would like to thank the reviewers and the editor for their valuable comments and insightful suggestions, which have significantly improved the quality and clarity of this article.

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Resumen:

Este artículo reflexiona sobre las cambiantes dimensiones jurídicas, éticas y culturales de la eutanasia, especialmente la eutanasia pasiva, tal como se contempla en el artículo 21 de la Constitución de la India. El documento traza los hitos jurídicos cruciales, desde *Gian Kaur contra el Estado de Punjab* (1996) hasta *Aruna Shanbaug contra la Unión de la India* (2011) y *Common Cause contra la Unión de la India* (2018), señalando la transición en la jurisprudencia judicial, en la que el derecho a morir con dignidad ha sido cada vez más reconocido. Se examinan las contradicciones conceptuales entre la autonomía y la inviolabilidad de la vida desde una perspectiva bioética global, contextualizando las experiencias indias. Incluso con los avances judiciales, la práctica de la eutanasia pasiva se ve ahogada por la hipotrofia procesal, la intransigencia institucional y el equívoco social. El documento también plantea cuestiones sobre la utilidad de los testamentos vitales, las limitaciones de la decisión de 2024 del Tribunal Superior de Delhi y el vacío legislativo existente. Defiende un enfoque de los cuidados al final de la vida basado en los derechos, culturalmente competente y legislativamente sólido, que respete la dignidad humana y la responsabilidad ética. Por último, exige una transición de la tolerancia judicial a la disposición sistémica y defiende la conveniencia humana y social de la reforma legislativa.

Palabras clave:

Eutanasia pasiva, derecho a morir con dignidad, jurisprudencia sobre el final de la vida, bioética en la India, voluntades anticipadas (testamento vital).

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1. INTRODUCTION

Euthanasia and its issues are a complex mix of challenging legal precedents, religious and culturally bound ethical perspectives, and the rights guaranteed by the Constitution of India (Berestova *et al.* 2019). It is essential to categorize euthanasia as active or passive for legal and ethical examination: active,[1] when life is directly terminated; passive,[2] when life is either not sustained or is withheld (Vadeyar and Singh 2013). This difference is significant because the two types, thus described, have been treated differently and with differing degrees of moral and ethical respect by the legal systems under which they have been governed (Roberts and Termuehlen 2021).

FIGURE 1

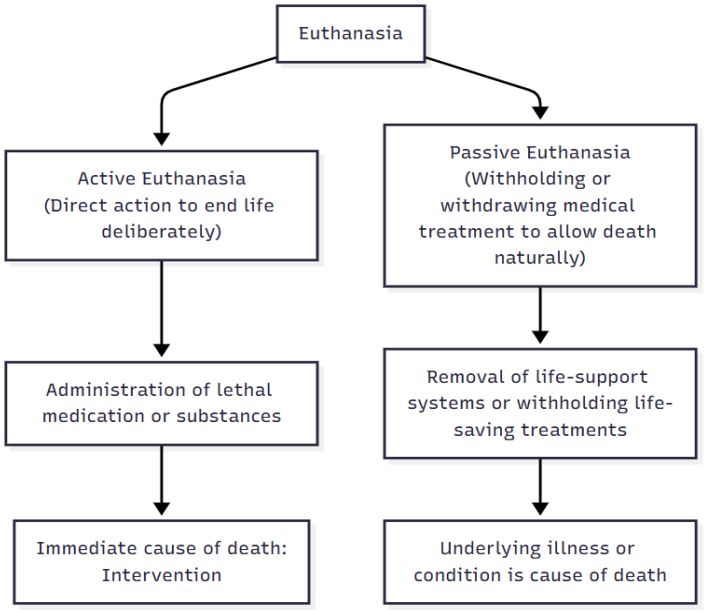

Figure 1. Active and Passive Euthanasia.

This debate should prompt a critical examination of the foundations of medical ethical principles, including autonomy, beneficence, non-maleficence, and justice, which are the cornerstones of medical ethics globally but serve different purposes in various cultural contexts in India (Miller 1995). It is essential to understand the opposing views on euthanasia, including physician-assisted death[3], to form a comprehensive view of end-of-life care policy. The legitimacy of euthanasia is also clouded by the ambiguities regarding

[1] Deliberate intervention by medical professionals or others to end life, typically by administering substances or treatments causing immediate death. Unlike passive euthanasia, active euthanasia is generally illegal in most jurisdictions.

[2] Euthanasia involves allowing a person to die naturally by withholding or withdrawing life-sustaining medical treatment or interventions, typically in cases of terminal illness or irreversible conditions.

[3] Physician-assisted death refers to a practice where a doctor provides means for a patient to end their life, typically via prescribed lethal medication, distinct from euthanasia, where the doctor directly administers it.

advance directives,[4] under which people can state their preferences for the kind of medical treatment that they would like to receive if they are rendered incapable of expressing their wishes (Salins *et al.* 2022).

The principle of autonomy, one of the fundamental pillars of modern bioethics, holds that individuals can make informed decisions regarding their bodies and lives, including when and how they die (Grignoli *et al.* 2018). It is not always an absolute right; it conflicts with the balance of social ideas, the sanctity of life, and the role of the State in protecting its citizens. In India, which tends to prioritize collectivist principles[5] more than individual rights, the concept of end-of-life autonomous choice meets much opposition. This complexity is further compounded by the involvement of various parties, including family members, healthcare professionals, and the legal system, which may hold different views and interests. The philosophical and cultural significance of death and its impact on the death experience further complicate this debate.

2. Legality of Euthanasia in India

The legal aspect regarding euthanasia in India has developed through various high-profile court judgments wherein the right to die a dignified death in some instances is being made increasingly acceptable. The judiciary has significantly influenced the interpretation of constitutional clauses regarding the right to life and personal liberty, which has evolved to encompass the development of a right to refuse medical treatment (Ahmed and Ali 2013, Alanazi *et al.* 2024).

It is crucial to formulate guidelines to prevent potential abuse and safeguard vulnerable individuals from coercion or undue influence (Miller and Fletcher 1993). These protections usually consist of requirements for medical review, psychiatric consultation, and court supervision to ascertain the voluntariness of the decision to end life and the understanding thereof. The Indian Penal Code provides immunity against criminal liability,[6] which should be meticulously considered to avoid undesirable implications for end-of-life care medical practitioners (Mani 2015).

The quality of life decisions, including who to treat and when to treat them, are further exacerbated by the practical difficulties of delivering quality palliative care across India. Palliative care, which aims to alleviate pain and suffering and enhance the quality of life for those with a potentially life-threatening illness, has sometimes been presented as an alternative to euthanasia by addressing the root causes for which the patient wishes to die. However, access to palliative care is limited, particularly in rural communities, leaving many patients with no recourse as their pain and suffering worsen. There is a great deal of cultural and religious variability concerning what people believe about end-of-life (EOL) issues, with

[4] Advance directives are legal documents in which individuals express their preferences for medical treatment in situations where they may become incapacitated and unable to communicate their decisions.
[5] Collectivist principles emphasize the values, norms, and interests of the community or family over individual autonomy, often shaping medical and ethical decisions in cultures where communal harmony and interdependence are prioritized.
[6] Legal responsibility pertains to actions or omissions that are classified as crimes under penal law, which can subject individuals to prosecution and punishment.

some traditions seeing suffering as an essential part of the dying experience and others stressing that life should be prolonged at all costs (Blank 2011).

The enduring debate on euthanasia in India must culminate in a contentious issue that involves a combination of judicial reforms, moral codes, and the establishment of healthcare facilities. In addition, the international view of EOL decision-making underscores wide cultural diversity, thereby emphasizing the importance of a culturally sensitive approach that respects different values and traditions (Blank 2011).

The comprehensive education and training of healthcare professionals are crucial for facilitating informed and empathetic communication with patients and their families regarding end-of-life care (Ohr *et al.* 2016, Akdeniz *et al.* 2021). The focus on respecting the patient's treatment preferences is a fundamental ethical imperative (Kinlaw 2005). By addressing these issues, India can aspire to a kinder and fairer end-of-life care that respects individuals' autonomy while upholding the importance of kindness and dignity (Steinberg 2011). The legal status of euthanasia in India has evolved primarily through judicial interventions rather than legislative enactments. As a result, euthanasia remains a juridically sanctioned but operationally fragile right, recognized but rarely realized.

3. ETHICAL CONSIDERATIONS: AUTONOMY, SUFFERING, AND THE SLIPPERY SLOPE[7]

3.1. AUTONOMY AND DIGNITY

The debate on euthanasia in India explores the boundaries between individual autonomy and the State's paternalistic approach to life protection (Berestova *et al.* 2019). At the heart of the controversy is the dualism between an individual's right to autonomy, particularly in cases of intolerable suffering, and society's interest in protecting the vulnerable from possible coercion or manipulation (Vadeyar and Singh 2013). Advocates of active euthanasia believe that an individual's dignity and freedom ought to be recognized as a matter of right, and they should be allowed to escape life peacefully if confronted with intolerable pain and a wickedly poor quality of life (Miller and Fletcher 1993). This unique approach highlights autonomy, the principle that an individual has the authority over their own body and healthcare decisions. In contrast, those against euthanasia assert the sanctity of life, arguing that all human life is valuable and needs to be cherished no matter how worthless it has become. (Shetty 2024). They warn against abuse, especially in a society where there are socioeconomic imbalances and insufficient access to palliative care.

[7] This argument suggests that allowing a minor action could result in more serious or undesirable consequences, ultimately leading to morally problematic outcomes.

FIGURE 2

Figure 2. Conceptual Model—Balancing Autonomy and Sanctity of Life.

3.2. THE SLIPPERY SLOPE ARGUMENT

The "slippery slope" argument features prominently in the case against legalizing euthanasia, its detractors warning that letting people have help to die could devalue life until it is cheapened in some cases. Economic stress, social withdrawal, or institutional prejudice could channel vulnerable people into choosing death as an answer to their difficulties when they could have received help and support. Second, the lack of palliative care infrastructure in India raises concerns about individuals' ability to make informed decisions about end-of-life care. The existing legal structures reflect the historical debate, often from a moral or legalistic perspective, about the morality or criminality of suicide (Majumdar 2004). If a person's choice is free, it is further complicated by the insight that human decisions are always embedded in social environments and relationships (van der Geest and Satalkar 2019).

TABLE 1

Bioethical Principle	**Definition**	**Indian Cultural Contextualization**	**Practical Challenges in India**
Autonomy	Individual's right to decide	Often subordinated to family and community interests	Limited practical exercise of autonomy due to collective decision-making
Beneficence	Duty to do good	Often aligned with community values of care	Unequal distribution due to resource scarcity
Non-maleficence	Duty to avoid harm	Cultural emphasis on prolonged life can conflict with patient's wish to end suffering	Underdeveloped palliative care services
Justice	Fair distribution of resources	Significant regional, caste, and socioeconomic disparities	Unequal access to healthcare services

Table 1. Bioethical Principles and their Indian Contextualization.

The term "aid-in-dying" is introduced as a rhetorical framework by which to reconceptualize the act of killing as "aiding" (someone who wants to die): helping them out when they have made a conscious and informed choice to want to die (Beauchamp 1999). The intricacy of the decision-making process is further emphasized by the involvement of both rationality and emotion (Prado 2013). The current Indian law permits passive euthanasia with safeguards in place, essentially serving as a somewhat restrictive and cautious measure to prevent abuse or pressure on the patient. Others, however, tend to advocate for a more subtle reading of the right to life, which includes a right to a decent death. This perspective opposes the traditional view that the State is the sole guardian of life and instead supports the recognition of an individual's right to determine their fate, especially in cases of serious illness or unbearable suffering.

FIGURE 3

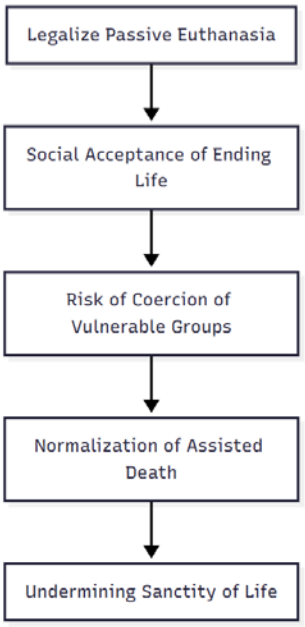

Figure 3. Slippery Slope Argument Against Euthanasia in India.

4. LEGAL LANDSCAPE IN INDIA

4.1. LEGAL TRAJECTORY: FROM *GIAN KAUR* TO *COMMON CAUSE*

The legal path of euthanasia in India has been guided more by judicial rulings than legislative clarification. However, over the last thirty years, Indian courts have moved from outright denial of a right to die to a more nuanced acceptance of passive euthanasia under certain conditions. A comparative summary of four key cases that have shaped this emerging law is presented in Table 2.

From *Gian Kaur v. State of Punjab* (1996), which upheld the criminalisation of suicide and rejected euthanasia, to *Aruna Shanbaug v. Union of India* (2011), which permitted passive

euthanasia in certain circumstances and said that the Hindu perspective of life is broad enough to accept the concept of death as a counterpart of life, the legal journey has traversed quite some distance. *Common Cause v. Union of India* (2018) took the discussion a step forward, having found advanced directives and living wills to be legally binding. Most recently, we were reminded of the ongoing procedural deficits and the need for legislation by the *Delhi High Court's judgment* in 2024. These decisions provide a window onto a transition from moral as well as constitutional opposition to a hesitant, court-led acceptance, but crucial ambiguities persist in practice and policy.

TABLE 2

Landmark Judgment	**Year**	**Euthanasia Type Recognized**	**Key Judicial Outcomes**	**Legal Implications**
Gian Kaur v. State of Punjab	1996	None (rejected)	Suicide criminalized; No inherent right to die	Foundation for legislative rather than judicial reform
Aruna Shanbaug v. Union of India	2011	Passive (under conditions)	Judicial guidelines for passive euthanasia	Emphasis on judicial oversight; narrow eligibility criteria
Common Cause v. Union of India	2018	Passive (with advance directives)	Recognition of 'Living Will'; Judicial and medical oversight required	Institutionalization of advance directives, but procedural complexities persist
Delhi High Court Judgment	2024	Passive (narrow interpretation)	Highlighted procedural limitations and gaps	Reinforced need for comprehensive legislation

Table 2. Key Court Judgments—Comparative Overview of Judicial Decisions.

4.1.1. *Gian Kaur v. State of Punjab* (1996)

In the history of Indian constitutional law, *Gian Kaur v. State of Punjab* assumes an important place, particularly in molding the scope of *Article 21* of the Indian Constitution[8], which embodies the right to life (Mani 2015). The instant case emanated from a petition seeking a declaration of unconstitutionality of *Section 309* of the Indian Penal Code (IPC), which criminalizes the attempt to end one's life (Vadeyar and Singh 2013). The petitioners

[8] Article 21 of the Indian Constitution guarantees that no person shall be deprived of their life or personal liberty except according to the procedure established by law. Its interpretation has expanded to include the right to live with dignity.

argued that the right to life under *Article 21* should be read as including the right to die and held that the criminalization of attempted suicide was unconstitutional.

The Supreme Court, in its reasoning, conducted a detailed analysis of philosophical, ethical, and juridical aspects of the right to life *vis-à-vis* the idea of suicide and eventually rejected the above claim (Majumdar 2004). Here, the court held that the right to life is inherent to natural rights, and it is contrary to suicide, an unnatural act of termination pregnant with life (Rao 2021). This distinction was the basis of the Court's finding that the constitutional validity of *309 IPC* (attempted suicide being thereby criminalized) was held to be constitutionally valid. This historic ruling is likely to have broader implications for the debate on euthanasia and the right to die with dignity in India, establishing that all forms of euthanasia must have legislative support as a result of this decision (Shetty 2024).

The analytical foundation of the Supreme Court's judgment in *Gian Kaur* was based on a fundamental distinction drawn between the right to life as a natural right and suicide as a contrasted act of unnatural termination of life; it was a view that was arrived at to the effect that the right to life as guaranteed by the Constitution of India did not include the right to take it (Bilimoria 1995). Such interpretation is based on the fact that the aim of *Article 21* is to preserve and safeguard life but not the termination thereof (Berestova *et al.* 2019).

The significance of the judgment upholding *Section 309* of the Indian Penal Code lies in its demonstration of society's concern for human life and its recognition of the state's duty to protect vulnerable groups from self-destruction. Secondly, the Court recognized that if the legal right to die were more widely accepted, there would be potential for misuse and abuse, particularly in a society facing economic pressures and emotional strains that might lead individuals to contemplate taking their lives. *Gian Kaur* serves as a poignant reflection of the delicate balance that must be struck between individual autonomy and societal values, on the one hand, and State obligations to protect the lives of its people, on the other, and serves as a testament to the courts' role in mediating these competing claims. The ruling regarding life is so clear and underscores the sanctity of life and the State's duty to protect its citizens, even from themselves (Feldman 2006).

The implications of *Gian Kaur* extend beyond suicide. The *Gian Kaur* judgment has consequences beyond the non-attempted suicide per se. It throws more than a small quantity of shade over the Indian euthanasia/assisted suicide debate. The court, in clear terms, declared that any kind of euthanasia, active or passive, would need parliamentary sanction, as a result of which the court could not have legalized it in the absence of a legislature. This position is both cautious about facilitating the end of one's life and about the necessity of a robust legal regime to govern such practices, ensuring that processes are in place to prevent mistakes or abuses and protect the rights of vulnerable people. The ruling illustrates the importance of the legislative process and public debate in shaping end-of-life care policies. The *Gian Kaur* decision has marked a significant milestone in the ongoing discourse on dignity in dying, potentially highlighting the delicate equilibrium between personal liberty and the value of human life. The courts concurred that the proper regulation of end-of-life decisions must lie in an articulated legal structure (Mathew 1996).

The *Gian Kaur* judgment has not entirely ruled out the existence of a right to die with dignity in some situations, as it affirms the constitutionality of criminalizing suicide attempts

and emphasizes that there must be legislation regarding euthanasia. The pattern in the Indian legal system, for treatment exemptions, has shown slow progress and growing maturity; the Supreme Court has recognized passive euthanasia[9] since *Aruna Ramachandra Shanbaug v. Union of India* on varied strict conditions.

4.1.2. *Aruna Shanbaug v. Union of India* (2011)

The *Aruna Shanbaug v. Union of India* case in 2011 has defined the legal and ethical guidelines on euthanasia in India, particularly for people suffering from persistent vegetative state[10] (Becker-Schwarze 2005). This historic judgment was motivated by the sad plight of Aruna Shanbaug, a nurse who was living brain-dead for 37 years after being sexually tortured (Vadeyar and Singh 2013). The Supreme Court was brought into the picture following a petition filed by journalist Pinki Virani, demanding an end to the medical support that kept Shanbaug alive (Shetty 2024). The Court has agonized over fundamental questions in the domain of the right to die with dignity, the sanctity of life, and the duty of the state to protect the weak, feeble, and helpless (Mani 2015). Although it had declined active euthanasia, the court estimated the acceptability of passive euthanasia in extremely narrow situations as a significant change in the legality of judging end-of-life (Berestova *et al.* 2019). That ruling recognized the moral ambiguity around prolonged suffering and the necessity of considering autonomy and dignity, even for those unable to communicate their wishes. The pioneering judgment emphasized the importance of judicial control in sensitive matters. A high court's consent was necessary as a condition precedent to carry out passive euthanasia (Salins *et al.* 2022).

The judgment of the Supreme Court in the *Aruna Shanbaug case* shows the Court's balanced approach to the moral and legal issues involved in euthanasia. The court emphasized the need to balance the protection of life against the alleviation of suffering, particularly when there is no hope of recovery and the quality of life has significantly deteriorated. According to the ruling, passive euthanasia is only acceptable in cases when an individual is in a permanent vegetative state or is in a terminal condition with no chance for recovery (Miller and Fletcher 1993). Furthermore, the court mandated a rigorous verification process that includes review by the medical community and the judiciary to eliminate any potential abuse and ensure that it is in the patient's best interest. The fact that neither the left nor the right is vehemently objecting to these procedures undercuts the claim that the court lacks credibility in providing fair treatment to those suspects. Therefore, the *Aruna Shanbaug judgment* established a legal foundation for passive euthanasia in India, guided by strict judicial guidelines that recognized the right to die with dignity in cases of prolonged and irreversible suffering (Mathew 1996).

The *Aruna Shanbaug case* provided the leeway for sympathy-based jurisprudence in cases involving terminal diseases, serving as a precursor for further legal and ethical debates regarding end-of-life care (Ahmed and Ali 2013). The Supreme Court has respected

[9] The court allows a person to die naturally by withholding or withdrawing life-sustaining medical treatment or interventions, usually in cases of terminal illness or irreversible conditions.

[10] A medical condition characterized by the loss of cognitive functions with retained autonomic bodily functions; the patient shows no meaningful responsiveness or awareness.

personal freedom and self-respect by accepting the autonomy and morality of passive euthanasia under certain conditions, protecting individuals from irreversible torment.

Upholding the value of autonomy is essential. However, there are several challenges (Alanazi *et al.* 2024). The judgment drew attention to the need to balance the State's responsibility to preserve life with an individual's right to choose a dignified life with minimal pain and distress (Akdeniz *et al.* 2021). This historic ruling has formed the basis for subsequent exegetical and policy developments concerning euthanasia in India. The spotlight fell on creating explicit standards and procedures for end-of-life care decisions to be made with the best interest of the patient in mind and based on ethical standards. The courts were starting to see the importance of personal choice and the necessity of a sympathetic approach to people who were struck by terminal illness and untreatable conditions.

Aruna Shanbaug case has revealed the complex relationships between law, ethics, and medical practice, particularly at the end of life, in a culturally diverse and legally pluralistic society like India (Bilimoria 1995). The centrality of judicial review, which serves to prevent possible abuse of euthanasia and to protect the rights of vulnerable persons, is entrenched (Azoulay *et al.* 2014). The right to die contradicts colonial legal paradigms, which considered suicide to be an immoral act (Majumdar 2004). The case also fueled a broader discussion in society about the moral, legal, and ethical aspects of euthanasia and the role of the state, the medical profession, and the individual in making end-of-life decisions. This subject matter includes the treatment of voluntary discontinuation of eating and drinking (VSED), surrogate decision-making, medical nutrition, cultural humility, and advance directives. It also emphasized the significance of measures such as comprehensive palliative care services and advanced directives in fulfilling individuals' end-of-life care wishes. While advanced directives are efforts to respect autonomy, decisions are not fixed and can be negotiated with family, significant others, and others who serve as surrogate decision-makers.

4.1.3. *Common Cause v. Union of India* (2018)

The historic *Common Cause v. Union of India* judgment is noteworthy in the legal and ethical debate concerning end-of-life practice in India when it decisively recognized the right to die with dignity as an inalienable component of the right to life guaranteed under *Article 21* of the Indian Constitution (Shetty 2024). This landmark judgment decriminalizes passive euthanasia and gives recognition to the use of "living wills," or advance directives,[11] by which a person could express their wishes concerning medical treatment in the event of their becoming unable to communicate with the physician (Vadeyar and Singh 2013).

Acknowledging advance directives by the court allows for representing a person's will in the event of his/her incompetence and contributing to exercising his/her right to decisions on health care, respecting that person's interest (Berestova *et al.* 2019). The ruling confirms the necessity of reconciling medical treatment with patients' preferences, even when they are unable to convey their wishes (Salins *et al.* 2022). They are also a legal tool to respect

[11] A written legal document by which a person specifies what actions should be taken regarding their health if they are no longer capable of making decisions themselves.

the autonomy and dignity of a person of sound mind who wishes to have their values and preferences respected, even in severe medical conditions (Bolcato *et al.* 2020). However, the way the judgment is structured—with numerous complex steps, including the formation of several medical boards, court approval, and extensive paperwork—indicates an apparent reluctance and pushback from institutions to fully adopt the positive changes the decision aims to support.

Even though these strict rules are meant to make sure that euthanasia choices are made carefully and not on a whim, they also show the profound uncertainty in society about end-of-life choices because of different reasons, like past laws that view suicide as wrong or sinful. This distinction might also stem from the fear of coercion in vulnerable individuals, which would mean a fine line between respecting autonomy and preventing harm. The judgment attempted to balance individual autonomy rights with broader societal interests, safeguarding against potential abuse while upholding the right to a dignified death. Both of these judgements have held that the right to life under *Article 21* cannot be interpreted to include a right to die a self-willed death, except for persons in a persistent vegetative state or people in a condition considered incurable and likely to die, sustained on artificial support, i.e., where their brain-dead bodies are turned into "cadavers" in the medical sense of the term, permitting their being allowed to have the plug of the life support system put off in the case of those futuristic advanced-stage patients who, after being fully conscious of their plight, seek the withdrawal of the artificial support of their physical life from the medical doctors (Bilimoria 1995).

According to the laws of crime, the act resulting in death must be committed knowingly and intentionally (Mani 2015). Although the advantages of advance directives (ADs) have been proven in numerous studies, their use is often limited due to several factors, including limited knowledge, cultural barriers, and physicians' opinions (Arenson *et al.* 1996). Decisions about care at the end of life are ethically complex, particularly when balancing the responsibility to sustain life with the right to a dignified death (Azoulay *et al.* 2014).

The informed consent process has developed over time and emphasizes honoring an individual's rights in making treatment decisions (Schneiderman and Teetzel 1996). Knowledge of the bioethical principles of biomedical ethics is essential for healthcare professionals when confronting complex dilemmas in end-of-life care (Akdeniz *et al.* 2021). Cultural and religious values have a significant role in EOLC concerning preferences, emphasizing the importance for health professionals to be culturally sensitive and respectful of diverse views (Ohr *et al.* 2016). Thus, palliative care becomes a pivotal component in this discussion by focusing on relieving suffering and improving the quality of life for patients with serious illnesses through the provision of expert pain and symptom management as well as the support of complex medical decisions that are commonly made at the end of life (Kinlaw 2005, Alanazi *et al.* 2024).

4.1.4. Recent Developments: Delhi High Court (2024)

In its recent verdict related to passive euthanasia, the Delhi High Court has once again highlighted the complex relationship between laws and suffering in matters that concern death (Shetty 2014). The court's strict adherence to precedent underscores the challenges of translating abstract legal principles into practical support for individuals with incurable

conditions (Vadeyar and Singh 2013). This judgment provides an essential landmark for contemplating the current jurisprudence on making end-of-life choices in India, in particular, because attitudes of society toward death and dying are changing (Berestova *et al.* 2019). The matter before Justice Subramonium Prasad was that of a 30-year-old quadriplegic man whose family wanted euthanasia owing to his vegetative state and their inability to provide for his continuous care, emblematic of the painful choices that families are compelled to make when they are pushed into an abyss of prolonged suffering and scarce means.

While the court acknowledged the family's anguish, it continued to rely on a narrow interpretation of the valid legal standards, prioritizing the observance of formal legal rules over compassion. The judgment is made against a backdrop of global debate surrounding care at the end of life, the role of the law, and differing legal and ethical imperatives that influence when and how euthanasia and assisted suicide are available and used (Bilimoria 1995). The landscape of uneven access to palliative care and healthcare resources generally demonstrates the range of risks that the court accepted. In a lawless environment, the court may have ruled, "If you have it, use it; if not, use it at your own risk."

The court's reiteration that not being terminally ill or dependent on life-supporting measures alone cannot be a disqualifying feature is also consistent with the famous *Common Cause (V)*, which is the foundation for the law on passive euthanasia in India (Salins *et al.* 2022). This precedent raises concerns about end-of-life decisions, but it has limitations that can disqualify those who suffer but don't meet the qualifying conditions, as was the case before the Delhi High Court. The decision highlights the importance of enacting more detailed and sophisticated legislation that enhances our understanding of end-of-life care by incorporating the diverse experiences and circumstances of patients, supporters, and relatives, especially when access to euthanasia cannot be provided to all those who are highly distressed due to narrow legal definitions.

The court's opinion points out the need for legislation that is both clear and transparent, grounded in respect for individual autonomy and broader social concerns, to guide the process of making end-of-life decisions. These decisions are commonly informed by various factors—some personal, others cultural and medical. The decision calls for an implicit public discourse on death and dying, the ethical dimensions of end-of-life issues, and the judiciary's involvement in these controversial matters; additionally, clinicians should be knowledgeable about these topics (Ahmed and Ali 2013). Cross-cultural differences in end-of-life treatment issues also bring the role of religious, cultural, family, and other social institutions into relief as these issues are constructed (Blank 2011).

The judgment of the Delhi High Court further demonstrates the value of advance care planning (ACP) in achieving optimal outcomes and respecting individuals' wishes at the end of their lives. Advanced care planning enables people to express their wishes for medical treatment and end-of-life care, encouraging autonomy and supporting informed decision-making when incapacitated. In the absence of advanced directives, families and healthcare providers can find themselves in ambiguity and conflict in determining the optimal response, particularly for incapacitated individuals (Kinlaw 2005). This statement implicitly recognizes the need for greater awareness and access to advanced care planning resources, such as living wills and healthcare proxies, to increase the opportunities for

people to make informed decisions about their end-of-life care. "AD will help protect the patient's autonomy during a time when they are no longer able to speak and express their willingness or refusal to receive treatment." (Sedhom 2017) In end-of-life care, the issue may be related to patient autonomy—the ability of patients to make their healthcare decisions that reflect their values and lifestyle (Alanazi *et al.* 2024). The ruling may pave the way for similar discussions, and perhaps reforms, under Indian law regarding the definition and scope of passive euthanasia in India.

FIGURE 4

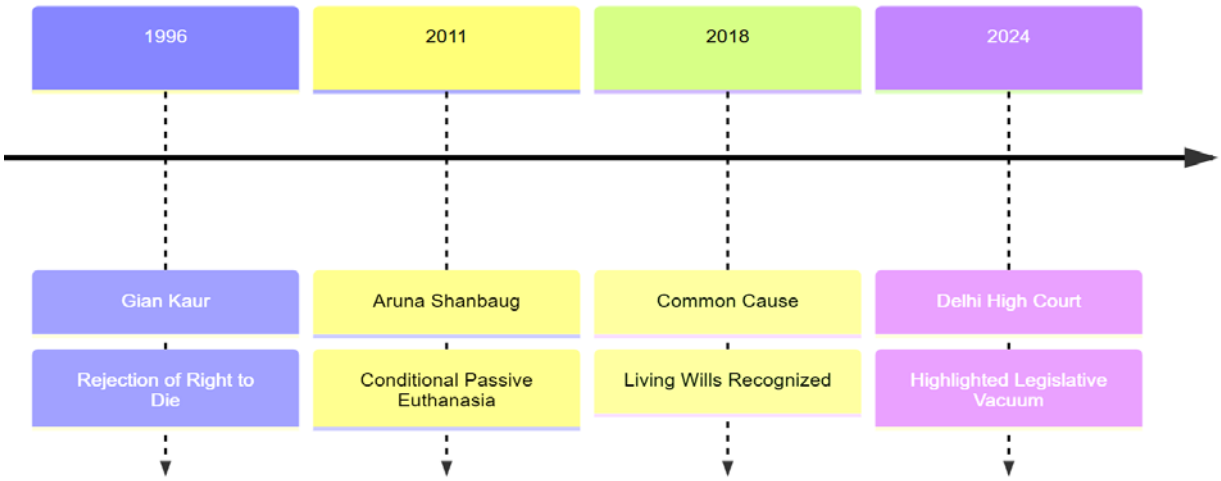

Figure 4. Timeline of Landmark Judicial Decisions.

Significantly, the High Court did not discard the law laid down in *Common Cause*; on the contrary, it reiterated the principles of the said case, especially regarding procedural safeguards and qualification for passive euthanasia. However, it construed these principles narrowly and literally, which restricted the more generous spirit that *Common Cause* seemed to embrace. In so doing, the Court neither extended nor reinterpreted the precedent; instead, it further fortified it, adding a layer of procedural rigidity that had already been built into it. This makes the Delhi ruling a reaffirming judgment rather than a transformative one, but what is significant is that it exposes the exclusionary implications of a dogged application of precedent. Therefore, even though *Common Cause* provided a judicial imprimatur to advance directives and passive euthanasia in carefully defined situations, the decision of the High Court is an emblem that many terminally ill patients outside the framework may not have the benefit of. Defining this interpretative stance here also points out the need for statutory reform to expand the definition of passive euthanasia beyond the strict judicial parameters.

4.2. Legislative Vacuum and Judicial Overreach

The euthanasia debate in India is complicated, partly because there is a lack of legislation, which forces the courts to create legal precedents (Shetty 2024). This vacuum has led the judiciary to stray into the legislature's field while trying to do justice to the rights and dignity of the individual. Hence, applying the laws might cause irregularities and non-uniformities (Miller and Fletcher 1993). Some have viewed this approach as judicial overreach, and

although it might more accurately be described as a judicial necessity, it remains an interventionist strategy to protect individual rights in the absence of parliamentary action. The absence of formal legislative mechanisms for euthanasia in India stands in This contrasts with other countries, such as the Netherlands, Belgium, and Canada, which have detailed laws regulating euthanasia to maintain a balance between patient autonomy and societal protections (Berestova *et al.* 2019).

FIGURE 5

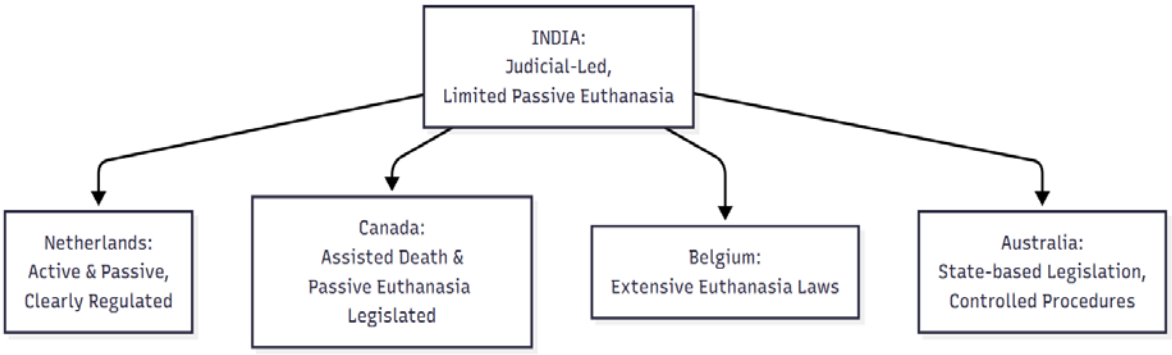

Figure 5. Comparative International Legal Frameworks.

The current approach to euthanasia in India, which relies primarily on court decisions, may result in unequal access to the procedure, inconsistent application of rules due to judicial discretion, and significant variations in Furthermore, individual cases may deviate from the ethical principle of personal autonomy in medicine (Vadeyar and Singh 2013). A historical context complicates things further; former colonial legal definitions of suicide as sinful, which have shaped contemporary debates around the right to die in a world with conflicting traditional and modern legal orders, are pertinent in this regard (Majumdar 2004).

The challenge here is the failure of the Indian Parliament to enact an appropriate law on euthanasia that lays down the guidelines, safeguards, and institutional mechanisms for it. This void in legislation has led the courts to assume the dual function of interpreter and maker of the law, which is not without difficulty, given the lack of a well-defined policy and the absence of some consultative professional opinion (Salins *et al.* 2022). The court risks usurping its constitutional role and violating the separation of powers doctrine by acting to preserve the rights of individuals who defy the legislative majority. In countries where euthanasia legislation exists, the law is generally assumed to rest upon the requirement that the individual is capable of a voluntary decision, which is subjected to elaborate medical and psychological examinations (van der Geest and Satalkar 2019). Additionally, they note that the majority of these laws require two doctors to verify the patient's health and prognosis, thereby providing an extra layer of protection against coercion.

With the Indian Parliament abdicating its duty to enact legislation on this issue, the courts have had to act as interpreters and, in effect, legislators, frequently in the absence of significant input from broad-based stakeholder bodies or professional consensus (Salins *et al.* 2022). However, where euthanasia is legalized, patient competence, voluntary decision-making, and medical prognosis are rigorously scrutinized with a standard protocol (with unfortunate consequences if misused) that involves a mandatory review by at least two doctors to curb misuse in countries where euthanasia is legalized (van der Geest and

Satalkar 2019). Such comparative legal certainty raises the question as to why the Indian legislator is not enacting a comprehensive, ethically grounded, and medically informed euthanasia law to provide consistency, transparency, and safeguarding of patient autonomy.

Although judicial rulings have filled the legislative void regarding euthanasia in India, it is important to note that the Law Commission of India has repeatedly recognized the urgent need for a statutory framework. The 196th Report (2006) on Medical Treatment of Terminally Ill Patients (Protection of Patients and Medical Practitioners) provided detailed guidelines for withholding and withdrawing life-sustaining treatment, the presence of an advance directive, and other related matters. It explicitly cited the lack of clarity in Indian law and made a case for statutory safeguards to reconcile patient autonomy with ethical medical conduct. The 241st Report (2012) reaffirmed several of these concerns, stating that there should be recognition of passive euthanasia and recommending draft legislation for public and parliamentary discussion. Despite such policy advice, no actual legislation has been enacted, underscoring the fact that the Indian Parliament has had both ample time and industrial freedom in deciding how to act but has failed to convert this advice into formal law. Citing these studies, they argue that it is not the judiciary's willingness that has caused the judicial branch to become more involved in end-of-life jurisprudence, but rather the unwillingness of the legislature to act—hopefully their reference to legislative inaction will convince further courts and legislatures to act.

5. Cultural and Practical Considerations

5.1. Cultural Attitudes Towards Death

In India's plural society, death is seldom a purely medical event; it is saturated with layered cosmologies of karma, rebirth, sin, sacrifice, and familial obligation. Hindu traditions value a "good death" (sāntimṛtyu) that involves mental composure, spiritual preparation, and the acceptance of suffering as karmic expiation; the Jain doctrine of sallekhana ritualizes voluntary fasting unto death as an act of spiritual purification; Islamic jurisprudence supports the preservation of life, but it recognizes that "futile" treatment may be withdrawn under the principle of lā ḥaraj (no undue hardship). At the same time, several Christian denominations emphasize the concept of redemptive suffering while also accepting the principle of refusing disproportionate treatment. Families in these religions usually confer with other local elders or clergy members before making decisions regarding a person's end of life. Therefore, an explicit request for euthanasia or even an advanced declaration may be viewed as an act of impiety, going against the divine will, or as a sign of impending social decline. This communitarian ethic clashes with the liberal-individualist foundation of the Supreme Court's autonomy-oriented jurisprudence, and the result, as Inbadas (2017) puts it, is a "moral dissonance" between constitutional rights talk and the everyday culture of death. Any legal structure that disregards these vernacular theologies will risk being underused and result in hidden forms of coercion, as the family and community secretly counteract the explicit wishes of patients to comply with what they see as religious or social norms.

5.2. Challenges in Palliative Care

The moral urgency that undergirds calls for euthanasia cannot be separated from the abysmal gaps in the palliative care infrastructure in India. While the National Programme for Palliative Care (2012) proposed an ambitious target for coverage, less than 2% of those in India who need palliative care receive it, and coverage is heavily weighted towards urban settings (Alanazi *et al.* 2024). Regulatory impediments to opioid availability leave many cancer and end-stage organ failure patients without essential treatment for moderate to severe pain, with morphine provision restricted to approximately one-tenth of the global per capita requirement. There is a critical shortage of human resources; the country has approximately 300 trained palliative doctors and fewer than 1,000 specialist nurses for a population of 1.4 billion (Salins *et al.* 2022). Cultural stigmas discourage conversations about death, which in turn exacerbate the problem: clinicians feel forced into "false optimism," while families see realistic prognostic disclosure as abandonment, resulting in late referrals to hospice programs.

Financial toxicity is another contributor to the problem; the expense of prolonged critical care can impoverish households, and public insurance programs rarely cover home palliative care. The cumulative result is a scale of unnecessary misery, which taints popular understanding of passive euthanasia. For many families, the real choice is not between life-enhancing palliation and a doctor-induced death but between costly, medically pointless treatments and unrelieved misery. Until pain-relief infrastructure, community-based hospice networks, and culturally sensitive communication training become accepted features of health care in India, and people will appeal to the "right to die with dignity" less as an exercise of autonomous preference and more as a desperate solution to systemic neglect.

6. The Living Will: A Rights-Based Instrument?

In the wake of the Common Cause case, living wills were introduced as an institutionalized mechanism to codify the patient's autonomy in end-of-life care and to ensure that patients receive and, to some extent, decide upon that care for themselves. Society generally values the concept of advance directives, such as living wills, as an area that can facilitate patient autonomy at the end of life. Yet, the actual completion of these documents occurs at rates less than expected in each group (Arenson *et al.* 1996). The intricate and cumbersome verification process, which includes witness authentication, notarization, magisterial sign-off, and review by multiple medical boards, can cause irrevocable delays when emergencies arise (Sedhom 2017).

FIGURE 6

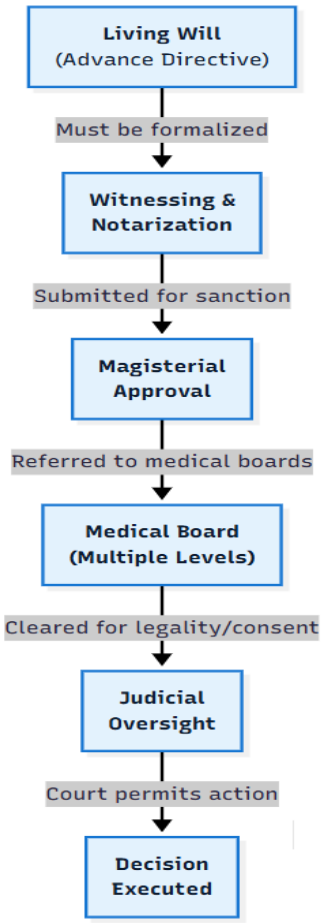

Figure 6. Procedural Complexity in Executing Living Wills.

The complex and time-consuming process of establishing an advance directive will significantly hinder the fulfillment of a patient's wishes during emergency decision-making. Compounding this issue is the prevailing lack of awareness concerning living wills, which extends not only to the general public but also to a significant portion of healthcare professionals (Vadeyar and Singh 2013). In ICUs, where it's important to respect what patients want, healthcare professionals may become doubtful about involving families, and complicated communication can make it harder to honor patient choices. Suppose medical professionals do not comprehend living wills. Healthcare providers may lack knowledge about the legal and ethical aspects of wills, which can result in potential losses (Ajluni 2023). As a result, the complicated and resource-intensive system, along with a lack of understanding, makes it difficult for living wills to help patients make effective decisions about their end-of-life care.

In addition, cultural and religious beliefs significantly influence preferences for end-of-life care, which complicates the use of living wills (Ohr *et al.* 2016). Cultural differences in attitudes toward death and dying can influence the acceptability and use of advance care planning (ACP) tools, such as living wills (Kogan *et al.* 2021). In some cultures, family considerations may take priority when making treatment decisions. However, the notion of family decision-making is not the same for all cultures. Furthermore, family disputes may

arise regarding how the patient's will will be interpreted and executed, especially when emotional distress and mourning influence judgment (Erlen 2005).

The gap between a patient's wishes, as expressed in known advance directives, and the beliefs or preferences of family members regarding the patient's care creates significant ethical challenges for healthcare professionals who must navigate multiple values while upholding their obligation to respect patient autonomy. Religious conviction may also influence views of medical treatment; for example, certain religions oppose all means to end life, including life-saving treatment, and contradict the patient's request to refuse treatment as outlined in their living will. This quandary is compounded by the fact that many assumptions in Western bioethics literature do not transfer readily to other cultural contexts (Blank 2011). Therefore, we need culturally sensitive strategies to guide the enactment of living wills across various patient and family belief systems (Blank 2011, Steinberg 2011).

TABLE 3

Step	**Requirement**	**Challenges**
Drafting the Will	The patient must voluntarily prepare a written living will	Low awareness; lack of standardized templates
Witness Authentication	Requires signatures of two independent witnesses	Difficulty in securing neutral and legally acceptable witnesses
Notarization	The document must be notarized	Legal costs and accessibility issues
Judicial Oversight	Must be countersigned by a First Class Judicial Magistrate (JMFC)	Time-consuming; limited access in rural/semi-urban areas
Storage and Registration	Will must be recorded and preserved by the JMFC	No national repository; poor tracking of directives
Activation in Emergency	On hospital admission, medical board must confirm patient's condition	Formation of multiple boards can cause delays in critical moments
Secondary Board Review	A second independent medical board must re-verify before withdrawal of care	Duplication of review leads to procedural stagnation

Institutional Consent	The final decision requires approval from hospital ethics committee (if present)	Ethical boards may be non-functional or non-existent in many healthcare institutions

Table 3. Procedural Hurdles in Executing a Living Will in India.

7. LIMITATIONS AND CHALLENGES

Despite the potential of the research method to advance equity in end-of-life decision-making, several limitations and challenges need to be addressed. The first concern is that data collection in underserved and rural communities is challenging due to logistical, linguistic, and cultural obstacles.

TABLE 4

Aspect	**Urban Areas**	**Rural Areas**
Access to Facilities	Multiple tertiary hospitals and palliative centers	Limited healthcare facilities and specialist services
Economic Resources	Higher income, more comprehensive insurance coverage	Greater financial constraints and reliance on out-of-pocket payments
Legal Infrastructure	Better administrative systems for implementing legal frameworks	Under-resourced legal and administrative capacities
Cultural Influences	Rapid adoption of modern healthcare practices	Traditional views and local customs influencing end-of-life decisions

Table 4. Comparative Analysis of Urban and Rural End-of-Life Decision-Making Disparities.

Effective engagement is often hindered by issues such as low literacy, poverty, and a lack of trust in institutional stakeholders. Second, it is a morbidly difficult task to define a "dignified death." Dignity has cultural, caste, and class-specific meanings and can be challenging to measure uniformly. Third, researcher bias is always a concern in contexts where social hierarchies are deeply entrenched, and unconscious biases related to caste, gender, or geography may influence both data analysis and the eventual results.

TABLE 5

Indicator	Women	Men
Average Age at Consult	Older than men	Generally younger
Functional Status	More severely impaired	Relatively better functional status
Symptom Burden	Higher symptom severity	Lower symptom burden
Surrogate Decision-Maker Capacity	Less likely to have capacity	More likely to have capacity
Disposition Post-Consult	Higher rate of discharge to hospice	Lower rate of discharge to hospice

Table 5. Comparative Analysis of Gender Disparities in End-of-Life Decision-Making.

This illustrates the importance of broad research teams that are community-informed and responsive to local needs and concerns. Fourth, there are important ethical implications for vulnerable populations that require careful consideration of consent, privacy, and emotional risk. Legal and institutional barriers—namely, the city-oriented structure of bureaucratic procedures—mean that even the best-intentioned policies fare poorly in rural or alienated regions. These linked issues highlight the challenges of conducting ethically responsible, methodologically rigorous, and socially responsive research on EoLC in the Indian context.

8. CONCLUSION

India and the saga of euthanasia Jurisprudence is a microcosm of the moral and legal challenges faced everywhere to balance the regard we have for the sanctity of life with the patient's right to a decent death. The constitutional acceptance of this right through Article 21, reinforced in *Common Cause v. Union of India* (2018), represents a step forward in realizing the role of autonomy for end-of-life decision-making. However, the implementation of this right continues to be thwarted by undue reliance on judicial discretion, lack of enabling legislation, and the sociocultural paradox of death and dying.

This essay shows that, even though the Supreme Court has greatly influenced discussions about bioethics—from initially denying suicide as a constitutional right in *Gian Kaur* to tentatively recognizing passive euthanasia in *Aruna Shanbaug* and then almost making advance directives official in *Common Cause*—the legal approach to euthanasia is still unsure, inconsistent, and scattered. The 2024 Delhi High Court judgment aptly reflects this, with legal formalism prevailing over an empathetic response to long-standing suffering. This case further highlights the inherent inadequacies in existing procedural criteria.

Furthermore, the ethical cornerstones of medical ethics, such as autonomy, beneficence, non-maleficence, and justice—the ones applicable universally in medical ethics—manifest differently in the Indian pluralistic context. Incompatible with the transplantation of Western bioethical models are the cultural orientation toward communal decision-making, the religious beliefs about what constitutes suffering, and the scarcity of palliative care infrastructure. Although living wills are legally accepted, they have low visibility, are challenging to implement, are culturally unacceptable, and are largely impractical.

A comprehensive statutory exercise must follow the judicial recognition of passive euthanasia as a fundamental right. Such legislation should include specific procedural safeguards, require the provision of adequate and consistent palliative and hospice care, provide medico-legal review processes, and safeguard the ethical quandaries confronting healthcare providers. Crucially, law reform in this area must be grounded by a 'rights-based approach' that locates patients' dignity, self-determination, and embodied experiences (and not their reduction to objects of legal calculus or moral paternalism) at the center of ethical and legal decision-making.

FIGURE 7

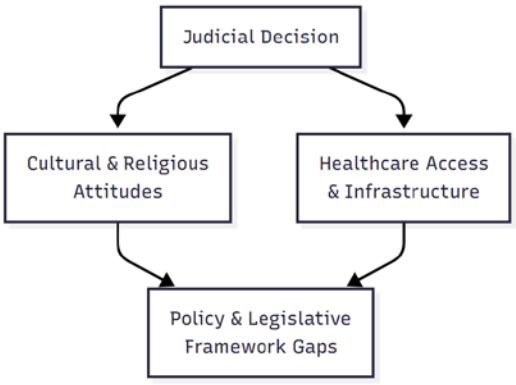

Figure 7. Interconnected Factors Shaping End-of-Life Jurisprudence in India.

We should expand the discourse on euthanasia beyond public courtrooms to include civil society, the academy, and the medical guild. This negative result cannot be oblivious to the structural inequities implicated in end-of-life care (from regional disparities in accessing healthcare to caste, class, and gendered hierarchies underpinning vulnerability and decision-making) into which this discursive entanglement intervenes. What India's forward march will entail is not just the legalization of euthanasia under controlled conditions but the humanization of euthanasia: the institution of a system in which decisions about the end

of life can be made in an enlightened manner and are supported in practice, and above all else, they are respected.

The case for reform is persuasive, but the policy path toward action is relatively nonspecific. For this judicial acknowledgement to be translated into meaningful and humane practice, targeted legal and institutional reforms must be implemented in India. The first need is for a comprehensive statutory framework under which passive euthanasia would be permitted, outlining unambiguous qualifications, procedural details, and the modalities for its medico-legal examination. Second, the administrative procedure for drawing up and registering advance directives must be made more practical (administratively unproblematic). That matter includes reducing administrative obstacles, streamlining the format used, increasing public awareness, and seeing to it that the patient and health professionals are adequately informed in such matters relative to the law. Third, the state needs to devote substantial resources to the development of palliative care infrastructure, especially in rural and underserved areas, so that the right to die with dignity does not remain the prerogative of the few. This set of measures, together, can help us move the discourse away from merely jurisprudential acknowledgement of euthanasia to a rights-based, ethically valid, and sociologically sound institutional model applicable to India.

In conclusion, India finds itself at a pivotal point in both law and morality. Euthanasia is a legal edifice but not yet a robust institution. The moral argument for dignity in dying is strong and compelling, but it needs to be informed and tempered by considerations of culture and context. If the country is to honor the constitutional guarantee of life with dignity, it must also make room for a dignified death as a fundamental right.

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