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Comparative Study on the Passive Euthanasia Laws of India and the Netherlands

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*Passive euthanasia, that is, the withdrawal or withholding of life-sustaining medical treatment from a patient with no reasonable prospect of recovery, lies at the meeting point of constitutional law, medical ethics and human rights. This paper undertakes a doctrinal comparative study of the passive euthanasia regimes of India and the Netherlands, two jurisdictions that arrived at legal toleration of hastened death through fundamentally different routes: India through progressive constitutional interpretation of the right to life under Article 21, and the Netherlands through dedicated statutory codification under the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002. The study traces the Indian judiciary's journey from *P. Rathinam v Union of India* through *Gian Kaur v State of Punjab*, *Aruna Ramchandra Shanbaug v Union of India*, *Common Cause v Union of India*, the 2023 procedural modification and the first practical application of the framework in *Harish Rana v Union of India* in 2026. It then examines the Dutch due care model, its review committee architecture and its extension to minors. Applying a chapter-wise, criteria-based comparison covering legal basis, patient autonomy, advance directives, decision-making authority, procedural safeguards, judicial oversight and protection of vulnerable persons, the paper finds that India's framework remains judicially engineered, procedurally cautious and confined strictly to passive euthanasia, while the Dutch model is legislatively sanctioned, physician-centred and considerably more expansive in substantive scope. The study concludes that wholesale transplantation of the Dutch model into India is neither constitutionally nor socio-economically feasible, but that India can selectively adopt Dutch procedural safeguards, particularly time-bound medical board review, standardised due care documentation and closer integration of palliative care, to strengthen the practical efficacy of its own dignity-centred jurisprudence without altering its present substantive scope.*

Keywords: *passive euthanasia, right to die, patient autonomy, article 21, comparative health law.*

INTRODUCTION

Meaning and Forms of Euthanasia: The word 'euthanasia' derives from the Greek eu (good) and thanatos (death), and denotes the deliberate ending of a person's life to relieve otherwise unbearable suffering.¹ In medico-legal usage, the term refers to an act or omission, undertaken with the primary intention of causing or hastening death, carried out by or with the assistance of a third person, at the request of, or in the best interests of, a patient suffering from an incurable or terminal condition. Euthanasia is conventionally classified along two axes, namely voluntary, nonvoluntary or involuntary, depending on whether the patient consents, is incapable of consenting, or objects, and active or passive, depending on whether death is caused by a positive act or by an omission.

Active euthanasia involves a positive, direct act, typically the administration of a lethal drug, undertaken by a physician with the specific intent of causing death. Passive euthanasia, by contrast, involves an omission, that is, treatment which is either not commenced or is discontinued, allowing the underlying disease process to take its natural course.² Although the moral distinction between killing and letting die has been contested by philosophers who regard the two as morally equivalent in outcome, the distinction remains legally decisive in most jurisdictions, including India, where active euthanasia continues to attract criminal liability for culpable homicide and abetment of suicide, while passive euthanasia enjoys constitutional protection subject to procedural safeguards.

Passive Euthanasia as an Extension of the Right to Refuse Treatment: Passive euthanasia is best understood not as an independent right to be killed but as the clinical and legal manifestation of the pre-existing right of a competent patient to refuse medical treatment, extended, through advance directives or surrogate decision-making, to patients who have lost decision-making capacity. The recognition by the House of Lords in Airedale NHS Trust

¹ Glanville Williams, *The Sanctity of Life and the Criminal Law* (Alfred A Knopf 1957) 275

² Law Commission, *241st Report on Passive Euthanasia, A Relook* (Law Com No 241, 2012) 6

v Bland that continued artificial feeding of a patient in a persistent vegetative state served no therapeutic purpose provided an influential comparative precedent for this reasoning.³

Right to Life and the Right to Die with Dignity: Article 21 of the Constitution of India guarantees that no person shall be deprived of his life or personal liberty except according to procedure established by law.⁴ Indian constitutional jurisprudence has progressively read into this bare guarantee a bundle of derivative rights, including the right to live with human dignity. The question whether this right extends to a right to die, and if so in what form, has occupied the Supreme Court for three decades, moving from an initial recognition of a right to die under Article 21 in *P. Rathinam*, its reversal in *Gian Kaur*, and its eventual, carefully circumscribed reaffirmation, limited to passive euthanasia, in *Aruna Shanbaug and Common Cause*.⁵

Need for the Present Comparative Study: A comparative study of passive euthanasia law serves both a doctrinal and a policy purpose. Doctrinally, it clarifies how differently structured legal systems, one built on judicially discovered constitutional rights and the other on express legislative codification, approach the same underlying ethical problem of end-of-life autonomy. From a policy perspective, such a comparison allows a receiving jurisdiction such as India to evaluate which procedural mechanisms of a more mature regime are transplantable, and which are unsuited to its demographic scale, healthcare infrastructure and socio-cultural context. The exercise is particularly timely because India's passive euthanasia framework received its first practical judicial application only in 2026, three decades after the debate first began, making an informed evaluation of comparative best practice both necessary and overdue.

Why India and the Netherlands are Chosen for Comparison: The choice of India and the Netherlands as comparators is deliberate rather than incidental. First, the two countries represent the two principal legal pathways by which a state may permit hastened death, namely constitutional or judicial recognition, as in India, and dedicated parliamentary legislation, as in the Netherlands. Second, the Netherlands was the first country in the world to codify euthanasia and physician-assisted suicide comprehensively, and its Regional

³ *Airedale NHS Trust v Bland* [1993] AC 789 (HL)

⁴ Constitution of India 1950, art 21

⁵ *P Rathinam v Union of India* (1994) 3 SCC 394; *Smt Gian Kaur v State of Punjab* (1996) 2 SCC 648

Euthanasia Review Committees have generated over two decades of empirical review data, making it the most studied and mature model globally and an ideal benchmark against which a comparatively nascent regime such as India's may be measured.

Third, both jurisdictions ground their frameworks in patient autonomy and human dignity, which permits meaningful doctrinal comparison despite their differing scope, since India restricts itself to passive euthanasia while the Netherlands additionally permits active euthanasia and physician-assisted suicide. Fourth, the contrast in scale, healthcare access and socio-economic context that is, a compact, high-resource welfare state as against a vast, resource-constrained, and demographically diverse democracy- allows the study to test whether procedural safeguards that are effective in one setting are realistically administrable in the other. This combination of structural difference and normative similarity makes the India Netherlands pairing considerably more instructive than a comparison between India and jurisdictions that merely share its common law ancestry without a comparably developed euthanasia jurisprudence.

REVIEW OF LITERATURE

Namrata Chakraborty, Reshma Renu and Sonakshi Kumar, 'Battle of Individual Autonomy, Euthanasia and Lawlessness: A Comparative Study with Reference to India, Netherlands and Australia'.⁶ This study examines the tri-jurisdictional experience of India, the Netherlands and Australia and concludes that the core difference between the Dutch and Indian positions lies in the absence, in India, of legislative willingness to convert judicial guidelines into a stable statute, a finding that directly informs the present paper's recommendation for codification.

Nikita Dalal, Sridhar Gupur and Rishika Varma, 'Euthanasia in India, Canada, Netherlands and Sweden with a Special Emphasis on Canada'.⁷ The authors survey four jurisdictions and observe that the Netherlands has moved furthest along the autonomy spectrum, extending eligibility even to persons who consider their life complete, a trajectory that this paper treats

⁶ Namrata Chakraborty et al., 'Battle of Individual Autonomy, Euthanasia and Lawlessness: A Comparative Study with Reference to India, Netherlands and Australia' (2021) 2(1) Indian Journal of Law, Polity and Administration 1 <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4306183> accessed 06 August 2026

⁷ Nikita Dalal et al., 'Euthanasia in India, Canada, Netherlands and Sweden with a Special Emphasis on Canada' (2022) 7(4s) BiLD Law Journal 112

as a substantive limit beyond which India is unlikely, and in the researcher's view ought not, to follow.

Pooja Kumari, 'Dying with Dignity: The Legal and Ethical Dimensions of Passive Euthanasia in India'.⁸ Kumari traces the historical and etymological roots of the concept and situates the Indian jurisprudence from P. Rathinam to Common Cause within the wider European debate, though without extending the analysis to the 2023 procedural modification or subsequent practical application, a gap the present paper directly addresses.

S. Anusree and Others, 'Exploring Euthanasia: A Comparative Legal Analysis of India's Constitutional Approach and Global Practices'.⁹ Drawing on the classical Dutch empirical study of Van der Maas and associates, the authors conclude that Indian law remains cautious and restrictive relative to the Netherlands, Belgium and Canada, and pose, without resolving, the question whether India should expand its framework toward active euthanasia, a question this paper answers in the negative for reasons of institutional and infrastructural readiness.

Pauline S.C. Kouwenhoven, Ghislaine J.M.W. van Thiel, Agnes van der Heide, Judith A.C. Rietjens and Johannes J.M. van Delden, 'Developments in Euthanasia Practice in the Netherlands: Balancing Professional Responsibility and the Patient's Autonomy'.¹⁰ This clinically grounded study records that euthanasia accounted for 4.5 per cent of all deaths in the Netherlands in 2015, the substantial majority performed by general practitioners, and identifies a gradual shift in the justification of Dutch practice from physician judgment toward patient autonomy, a trend the present paper relies upon in assessing the practical, as opposed to merely statutory, character of the Dutch model.

John Griffiths, Heleen Weyers and Alex Bood, *Euthanasia and Law in the Netherlands*.¹¹ This remains the foundational English-language account of the Dutch model's development from

⁸ Pooja Kumari, 'Dying with Dignity: The Legal and Ethical Dimensions of Passive Euthanasia in India' (2024) 14(4) *European Economic Letters* 1271 <<https://doi.org/10.52783/eel.v14i4.2256>> accessed 06 August 2026

⁹ Anusree et al., 'Exploring Euthanasia: A Comparative Legal Analysis of India's Constitutional Approach and Global Practices' (2025) 14(9) *Journal of Pioneering Medical Sciences* <<https://doi.org/10.47310/jpms2025140917>> accessed 06 August 2026

¹⁰ Pauline SC Kouwenhoven et al., 'Developments in euthanasia practice in the Netherlands: Balancing professional responsibility and the patient's autonomy' (2018) 25(1) *European Journal of General Practice* 240 <[10.1080/13814788.2018.1517154](https://doi.org/10.1080/13814788.2018.1517154)> accessed 06 August 2026

¹¹ John Griffiths et al., *Euthanasia and Law in the Netherlands* (Amsterdam University Press 1998) ch II

prosecutorial toleration to statutory codification, and its account of the due care criteria as products of case law rather than legislative fiat in the first instance is relied upon in Chapter IV of this paper.

Research Gap: The literature surveyed above addresses the Indian and Dutch frameworks either in isolation or as part of a wider multi-jurisdictional survey extending to Canada, Belgium, Sweden or Australia, and none of the available studies incorporates the 2023 procedural modification of the Common Cause guidelines or the first practical judicial application of the Indian framework in *Harish Rana v Union of India* decided in 2026. Existing comparative accounts also tend to describe the two regimes side by side without a sustained criterion-based analysis capable of identifying which specific Dutch procedural mechanisms, as distinct from its substantive scope, are realistically transplantable into the Indian context. This paper addresses that gap by undertaking a chapter-wise, criterion-based comparison current to 2026, and by distinguishing throughout between procedural learning, which the paper considers largely transplantable, and substantive expansion toward active euthanasia, which it does not.

Statement of the Problem: India's passive euthanasia framework, though constitutionally entrenched since *Common Cause v Union of India* in 2018 and procedurally simplified in 2023, continues to suffer from low public awareness, uneven rural healthcare capacity and persistent physician apprehension regarding legal liability, with the result that most eligible patients proceed through the more cumbersome surrogate best interests' route rather than through an advance directive. The Netherlands, by contrast, operates a mature, legislatively codified and empirically audited regime that has itself expanded significantly since 2002, including its 2024 extension to children between one and twelve years of age. The central problem this paper investigates is whether, and to what extent, India can strengthen the practical efficacy of its own dignity-centred jurisprudence by selectively drawing upon Dutch procedural safeguards, without thereby being drawn toward the more expansive substantive scope that the Dutch model now embodies.

Objectives -

1. To study the development of passive euthanasia law in India and the legal framework in the Netherlands.

2. To compare India and the Netherlands systems based on patient choice, decision-making, safeguards, court supervision, and protection of vulnerable people.
3. To suggest suitable Dutch safeguards for India to improve the existing passive euthanasia system.

Research Methodology: This study adopts a doctrinal method of legal research, relying primarily on the analysis of primary legal sources, namely the Constitution of India, the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002, and the judgments of the Supreme Court of India and the Dutch courts, together with secondary sources including law commission reports, peer-reviewed journal articles, edited volumes and official review committee reports. The comparative dimension of the study follows the functionalist tradition of comparative law, treating the withdrawal of life-sustaining treatment as the common underlying problem that both jurisdictions address through structurally different legal instruments, and evaluating each regime against a common set of doctrinal criteria rather than assuming the superiority of either model at the outset. No empirical fieldwork, survey or interview-based data collection has been undertaken, and the paper does not purport to offer clinical or statistical findings beyond those already published by the cited sources; its contribution lies instead in the doctrinal synthesis and criterion-based comparison of the two legal frameworks as they stand in 2026.

Hypothesis – India's judicially evolved passive euthanasia framework can be meaningfully strengthened by the selective adoption of specific Dutch procedural safeguards, particularly independent medical verification, defined procedural timelines and a transparent retrospective review mechanism, without requiring India to extend the substantive scope of its law to active euthanasia, physician-assisted suicide or euthanasia for minors.

EVOLUTION OF PASSIVE EUTHANASIA IN INDIA

The Traditional Legal Position: Before judicial intervention, Indian law treated any act or omission causing or hastening death as potentially falling within the offences of culpable homicide, murder or abetment of suicide under the Indian Penal Code, now substantially re-enacted as the Bharatiya Nyaya Sanhita 2023.¹² There was no statutory recognition of a right to refuse life-sustaining treatment, and physicians who withdrew such treatment risked

¹² Bharatiya Nyaya Sanhita 2023, ss 100-108

criminal exposure, creating a strong institutional incentive toward the indefinite, and often clinically futile, continuation of intensive care.

P. Rathinam v Union of India (1994): In *P. Rathinam v Union of India*, a two-judge bench of the Supreme Court held that the right to life under Article 21 included a right not to live a forced life, and accordingly read a right to die into Article 21, striking down Section 309 of the Indian Penal Code insofar as it penalised attempted suicide.¹³ The reasoning, though short-lived, remains significant as the first judicial acknowledgement that the right to life is not merely a right to biological survival.

Gian Kaur v State of Punjab (1996): This position was overruled two years later by a Constitution Bench in *Gian Kaur v State of Punjab*, which held that the right to life could not logically be construed to include its own extinction, and that the right to die with dignity at the end of natural life was conceptually distinct from, and did not authorise, an unnatural termination of life.¹⁴ The Court nonetheless left open, in obiter, the possibility that a terminally ill patient might possess a right to die with dignity, including the right to refuse extraordinary medical intervention, a seed that would germinate only fifteen years later.

Aruna Ramchandra Shanbaug v Union of India (2011): The case arose from a writ petition filed on behalf of Aruna Shanbaug, a nurse who had remained in a persistent vegetative state for over three decades following a criminal assault, seeking permission to withdraw artificial feeding. A two-judge bench of the Supreme Court, while declining to permit withdrawal on the facts since the hospital staff who had cared for her for decades did not consent, for the first time recognised that passive euthanasia could be permitted in India under strict judicial supervision, subject to High Court authorisation on a case-by-case basis following the opinion of a medical board.¹⁵ The Court adopted, with modification, the best interests test articulated in *Airedale*, and distinguished passive euthanasia, permissible in narrow circumstances, from active euthanasia, which it held remained unlawful and could be introduced, if at all, only through legislation.

K.S. Puttaswamy v Union of India (2017): The Supreme Court's recognition of privacy as an independent fundamental right in *K.S. Puttaswamy v Union of India* reinforced the doctrinal

¹³ *P Rathinam v Union of India* (1994) 3 SCC 394 [21]–[25]

¹⁴ *Gian Kaur v State of Punjab* (1996) 2 SCC 648 [24]–[25]

¹⁵ *Aruna Ramchandra Shanbaug v Union of India and Ors* (2011) 4 SCC 454 [39], [133]–[135]

foundation for treating medical decision-making, including the refusal of treatment, as an exercise of decisional autonomy protected under Article 21, and this reasoning was drawn upon directly by the Constitution Bench that decided *Common Cause* the following year.¹⁶

Common Cause v Union of India (2018): A public-spirited organisation, Common Cause, filed a writ petition seeking a declaration that the right to die with dignity is a fundamental right, and seeking recognition of advance medical directives. A five-judge Constitution Bench unanimously held that the right to life and personal liberty under Article 21 includes the right to a dignified death, encompassing the right of a competent, terminally ill patient to refuse medical treatment and the right of any adult to execute an advance directive specifying the circumstances in which life-sustaining treatment should be withheld or withdrawn should the person later lose decision-making capacity.¹⁷ In the absence of legislation, the Court exercised its power under Articles 141 and 142 to lay down a detailed procedure for the execution, custody and implementation of advance directives, including certification by multiple medical boards and confirmation by a Judicial Magistrate First Class.

The 2023 Procedural Modification: Medical practitioners' bodies, including the Indian Society of Critical Care Medicine, subsequently informed the Court that the 2018 guidelines, which required multiple layers of medical board certification and magisterial countersignature, were so cumbersome as to be practically unworkable and were deterring hospitals from honouring valid advance directives at all. On 24 January 2023, a five-judge Constitution Bench modified the 2018 guidelines, simplifying execution of an advance directive to require the signature of the executor before two witnesses, followed by attestation before a notary or gazetted officer, and streamlining the medical board certification process by prescribing defined timelines and reducing the direct procedural role of the Judicial Magistrate.¹⁸

Harish Rana v Union of India (2026): First Practical Application: The passive euthanasia framework developed in *Aruna Shanbaug* and *Common Cause* received its first concrete judicial application only in 2026. Harish Rana, a young man who had remained in a persistent

¹⁶ *Justice KS Puttaswamy and Anr v Union of India and Ors* (2017) 10 SCC 1 [297]–[300]

¹⁷ *Common Cause (A Regd Society) v Union of India* (2018) 5 SCC 1 [122]–[124]

¹⁸ *Common Cause (A Regd Society) v Union of India* (2023) SCC OnLine SC 99

vegetative state with complete quadriplegia for over thirteen years following a traumatic head injury, had no advance directive in place. His father's petition before the Delhi High Court for permission to withdraw life-sustaining treatment was rejected in 2024, leading to an appeal before the Supreme Court.¹⁹ On 11 March 2026, a bench of the Supreme Court authorised withdrawal of life support, applying the surrogate best interests procedure for patients without an advance directive as laid down in *Common Cause*, and clarifying that withdrawal of clinically assisted nutrition and hydration in such circumstances constitutes lawful passive euthanasia rather than an offence. The decision is significant not for altering the underlying legal test but for demonstrating, for the first time, the framework's functional capacity to deliver relief within the ordinary hierarchy of courts.

Present Legal Framework in India: Article 21 remains the sole express constitutional anchor for passive euthanasia in India, and no dedicated central legislation yet exists. The Supreme Court's guidelines, issued in exercise of its power under Articles 141 and 142, possess the force of law until Parliament enacts a comprehensive statute, an invitation the Court extended in both *Aruna Shanbaug* and *Common Cause* but which Parliament has not yet accepted.²⁰

The present framework, as modified in 2023, distinguishes between patients who have executed a valid advance directive and those who have not. For the former, the treating physician, upon confirming the patient's terminal or vegetative condition through a Primary Medical Board and a Secondary Medical Board, may give effect to the directive without further judicial intervention. For the latter, the patient's family or next friend may approach the hospital medical board and, if necessary, the jurisdictional High Court, which applies a best interests standard, as illustrated in *Harish Rana*.

Stage	Position under Common Cause (2018)	Position after 2023 Modification
Execution of directive	Signed before two witnesses; countersigned by	Signed before two witnesses; attested by

¹⁹ *Harish Rana v Union of India* (2026) SCC OnLine SC 358

²⁰ *Aruna Ramchandra Shanbaug v Union of India and Ors* (2011) 4 SCC 454 [135]; *Common Cause (A Regd Society) v Union of India* (2018) 5 SCC 1 [124]

	Judicial Magistrate First Class	Notary or Gazetted Officer, magisterial role removed
Custody of directive	Copies with Magistrate, District Court, hospital and family physician	Copies with local self-government custodian, hospital and family or surrogate
Verification	Primary Board, Secondary Board, then District Collector nominated Board	Primary and Secondary Boards within defined timelines, layers reduced
Role of Magistrate	Countersignature required at execution and implementation	Informational intimation only, no mandatory countersignature
No advance directive	Surrogate or family decision with hospital board and High Court approval	Same best interests surrogate procedure, applied in Harish Rana (2026)

Table 3.1: Procedural evolution of India's advance directive framework, 2018 to 2023.

Treating physicians bear primary responsibility for certifying the futility of continued treatment and for implementing a valid directive, and are statutorily and judicially shielded from criminal liability where the prescribed procedure is followed in good faith. Family members function as surrogate decision makers in the absence of a directive, subject to medical board and, where necessary, judicial oversight designed to guard against abuse, coercion or premature withdrawal motivated by non-medical considerations. Despite the 2023 simplification, awareness of the advance directive mechanism remains low, and Harish Rana confirms that the surrogate best interests' route, rather than the advance directive route, remains the more commonly invoked pathway in practice.

PASSIVE EUTHANASIA LAW IN THE NETHERLANDS

Historical Development: Dutch toleration of euthanasia developed initially through prosecutorial policy and judicial precedent from the 1970s and 1980s, well before formal legislation. Dutch courts progressively accepted a defence of necessity for physicians who terminated a patient's life in compliance with what later crystallised as due care criteria, developed through case law and the guidelines of the Royal Dutch Medical Association.

The Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002: The Netherlands became the first country in the world to codify the legality of euthanasia and physician-assisted suicide through the Wet toetsing levensbeeindiging op verzoek en hulp bij zelfdoding (Wtl), which came into force on 1 April 2002. The Act does not create a positive right to euthanasia. Rather, it provides a special defence to physicians charged under Articles 293 and 294 of the Dutch Criminal Code, provided the physician has observed the statutorily enumerated due care criteria and has reported the death to a municipal pathologist for review.²¹

Due Care Criteria:

Due Care Criteria	Requirement
Voluntary and Well Considered Request	The patient's request must be voluntary, durable and free of external pressure
Unbearable and Hopeless Suffering	The physician must be satisfied that suffering is unbearable and without prospect of improvement, though not necessarily terminal
Information to the Patient	The patient must be fully informed of the condition, prognosis and alternatives

²¹ Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 (Netherlands), art 2; Dutch Criminal Code 1926 (Netherlands), arts 293 and 294

No Reasonable Alternative	The physician and patient must jointly conclude that no reasonable alternative treatment exists
Independent Second Physician (SCEN)	An independent physician must examine the patient and give a written opinion on due care
Due Medical Care in Termination	Life must be terminated, or assistance given, with due medical care and attention

Table 4.1: Statutory due care criteria under the Dutch Euthanasia Act 2002.

Role of Physicians and the Regional Review Committees: Unlike the Indian model, which relies on multi-member medical boards and courts, Dutch law places primary decisional and evaluative responsibility on the individual treating physician, supported by an independent consulting physician commonly drawn from the SCEN programme. Every reported death is reviewed retrospectively, not prospectively authorised, by one of five Regional Euthanasia Review Committees, each comprising a legal member, a physician member and an ethicist. Only where a committee finds that due care was not observed is the matter referred to the public prosecutor and the healthcare inspectorate.²² A clinically grounded study by Kouwenhoven and associates records that euthanasia accounted for approximately 4.5 per cent of all deaths recorded in the Netherlands in 2015, with general practitioners performing the overwhelming majority of procedures, and identifies a discernible shift in professional justification from physician judgment toward patient autonomy over the intervening two decades.

Advance Requests and Incompetent Patients: The Dutch Act permits a written advance directive to substitute for a contemporaneous oral request where a patient has since become incompetent, provided the directive was made while the patient was capable and the physician independently verifies that the due care criteria, including unbearable suffering, are met. In 2020, the Dutch Supreme Court confirmed that physicians may act on a clear

²² *Annual Report 2022* (Regional Euthanasia Review Committees 2023)

advance directive even for patients with advanced dementia who can no longer confirm their wishes, subject to careful verification, a considerably more expansive position than the Indian framework, which currently confines advance directives to the withdrawal of treatment rather than active termination of life.²³

Extension to Minors and Continuing Evolution: The Dutch framework has continued to evolve well beyond the withdrawal of treatment. Since 1 February 2024, regulation permits euthanasia for children between one and twelve years of age suffering unbearably with no prospect of improvement, subject to parental consent and independent medical verification, extending a regime that had previously covered only patients twelve years and older, with parental involvement required for those between twelve and seventeen, and neonates. In 2026, the first reported case of euthanasia of a child under twelve since this extension was disclosed to the Dutch Parliament, reigniting domestic and international ethical debate.

Relationship with Palliative Care and Withdrawal of Treatment: Dutch law treats withdrawal or withholding of life-sustaining treatment at a competent patient's request, and the administration of pain relief that may incidentally hasten death under the doctrine of double effect, as ordinary medical practice falling entirely outside the Euthanasia Act, since these do not involve an intentional act to end life. The Act's due care regime is reserved for cases of active termination of life or physician-assisted suicide, meaning that passive euthanasia in the Indian sense is, in the Netherlands, not classified as euthanasia at all but simply as normal medical practice governed by the ordinary law of patient consent.

COMPARATIVE ANALYSIS

Criteria-based Comparison:

Criteria	India	Netherlands
Legal Basis	Judicial interpretation of Article 21, no dedicated statute	Dedicated statute, the WtI of 2002

²³ *Public Prosecutor v Physician* [2020] ECLI:NL:HR:2020:712

Scope	Passive euthanasia only, active euthanasia remains an offence	Active euthanasia, assisted suicide and treatment withdrawal all addressed
Primary Decision Maker	Medical Boards, treating hospital and courts	Individual treating physician with independent consulting physician
Patient Autonomy	Recognised, exercised through a heavily supervised procedure	Central organising principle, request driven model
Advance Directives	Permitted for withdrawal of treatment, simplified since 2023	Permitted for active termination, including incompetent patients
Review Mechanism	Prospective, Boards certify before withdrawal	Retrospective, Review Committees examine after death
Judicial Role	Central and continuing	Residual, prosecution only where due care is absent
Protection of Vulnerable Persons	Multi-tier certification, exclusion of interested parties	Independent second opinion, documentation and audit
Doctors' Liability	Immunity conditional on compliance with guidelines	Statutory defence upon proof of due care
Palliative Care Integration	Aspirational, access remains uneven	Well integrated, extensive hospice infrastructure

Table 5.1: Criterion-based comparison of the Indian and Dutch passive euthanasia frameworks.

Key Similarities: Despite their structural divergence, both jurisdictions converge on several common safeguards, namely a requirement of medical confirmation of the underlying condition, independent second opinion review, exclusion of decision makers with a conflicting interest, documentary preservation of the patient's wishes, and continuing institutional oversight, judicial in India and administrative cum prosecutorial in the Netherlands, designed to deter and detect abuse. Both regimes also anchor their frameworks in the twin principles of patient autonomy and human dignity, and both confine lawful hastened death to conditions of terminal illness, incurable disease or permanent loss of cognitive function, thereby declining to recognise a general right to end life on demand.

Key Differences:

Aspect	Restrictive, India type Feature	Autonomy based, Netherlands type feature
Trigger for Lawful Act	Terminal illness or persistent vegetative state certified by boards	Patient's voluntary, durable request
Timing of Review	Prospective authorisation required before withdrawal	Retrospective Review after death
Physician Discretion	Constrained by mandatory multi board certification	Substantial, subject to due care compliance
Legislative Status	Guidelines under Articles 141 and 142, no statute yet	Comprehensive dedicated statute since 2002

Table 5.2: Restrictive versus autonomy-based features of the two regimes.

The most fundamental structural difference between the two regimes is scope. India permits only the withdrawal or withholding of treatment, and the intentional administration of a life-

ending substance remains culpable homicide regardless of consent. The Netherlands regulates the entire spectrum, treating passive withdrawal as ordinary medical practice while separately regulating active euthanasia and physician-assisted suicide under the WtI, which makes the Dutch regime considerably more permissive in substance and not merely in procedure. India's layered, multi-board and court-supervised model reflects an institutional caution appropriate to a system introducing the concept across widely uneven healthcare capacity, whereas the Dutch model's reliance on individual physician judgment, checked by a second independent opinion and retrospective committee review, presupposes a uniformly high standard of physician competence and a mature culture of medical self-regulation that may not translate evenly across India's public and private healthcare sectors.

ISSUES, CHALLENGES AND THE JUDICIAL PERSPECTIVE IN INDIA

Practical Difficulties in Executing Advance Directives: Even after the 2023 simplification, execution of a valid advance directive requires access to notarial or gazetted officer attestation, a facility unevenly available outside urban centres, and continues to demand a degree of legal literacy and healthcare foresight that remains rare among the general population.

Lack of Public Awareness: Public awareness of the right to execute a living will remains extremely low, and the overwhelming majority of end-of-life cases, including Harish Rana, proceed through the surrogate best interests' route precisely because no advance directive was ever executed, underscoring a persistent gap between the existence of a legal right and its practical exercise.

Access to Palliative Care: India's palliative care coverage remains sharply skewed toward a small number of urban tertiary centres, leaving patients in rural and semi-urban areas without adequate pain management, a deficiency that undermines the humane objectives of the passive euthanasia framework and increases pressure for withdrawal of treatment for reasons of unmanaged suffering rather than considered choice.²⁴

Medical and Ethical Dilemmas, and the Risk of Family Pressure: Physicians operating multi-tier medical boards must reconcile professional obligations of beneficence with the risk

²⁴ 'Palliative care' (World Health Organization, 25 August 2020) <<https://www.who.int/news-room/fact-sheets/detail/palliative-care>> accessed 06 August 2026

of liability for erroneous certification, while surrogate decision-making by family members raises the possibility, acknowledged but not fully resolved by the current safeguards, that decisions may be influenced by the emotional, financial or caregiving burden borne by relatives rather than solely by the patient's best interests.

Protection of Persons with Disabilities and Other Vulnerable Patients: Disability rights advocates have consistently cautioned that any relaxation of safeguards around withdrawal of treatment risks devaluing the lives of persons with severe disabilities, particularly where societal and familial support systems for long-term care remain inadequate, a concern the Supreme Court has sought to address by confining the framework strictly to terminal illness and permanent vegetative state, and by excluding disability alone as a qualifying condition.

Rural Healthcare Limitations and Fear of Legal Liability: The requirement of two-tier medical board certification presupposes the availability of a sufficient number of qualified specialists at the treating hospital, a presumption often unmet in rural and district-level government hospitals. Combined with continuing uncertainty among practitioners as to the precise contours of legal immunity, this has produced documented reluctance among physicians to initiate withdrawal of treatment discussions even where clinically and legally warranted.²⁵

The Judicial Perspective: The trajectory from P. Rathinam to Harish Rana illustrates a distinctively Indian pattern of rights development, in which, in the continued absence of dedicated parliamentary legislation, the Supreme Court has functioned simultaneously as constitutional interpreter, guideline framer and, through its continuing supervisory jurisdiction, quasi-regulator of end-of-life medical practice. This judicial centrality distinguishes India sharply from the Netherlands, where the legislature enacted a comprehensive statute and courts play a comparatively conventional adjudicatory and review role. In both systems, courts have avoided articulating an absolute hierarchy among dignity, autonomy and the sanctity of life, preferring a contextual, criteria-based balancing exercise that confines the lawful zone of hastened death to defined medical conditions subject to procedural verification, rather than announcing a general right to die.

²⁵ Rohini Shukla, 'Passive euthanasia in India: a critique' (2016) 1(1) Indian Journal of Medical Ethics 84 <<https://doi.org/10.20529/ijme.2016.008>> accessed 06 August 2026

RECOMMENDATIONS

Legislative Codification: Parliament should enact a dedicated statute codifying the Common Cause guidelines as modified in 2023, converting judicially framed guidelines into a stable, unambiguous legislative code that reduces reliance on continuing judicial revisitation and provides physicians with clearer statutory immunity, comparable in structure, though not in substantive scope, to the Dutch WtI.

Simplification of Advance Directive Procedures: Digital registration of advance directives linked to a national health identification system, together with extension of attestation facilities to primary health centres, would meaningfully improve accessibility beyond the 2023 reforms, particularly in rural areas where notarial and gazetted officer facilities remain scarce.

Standing Medical Board Mechanisms and Doctor Protection: A standing, adequately staffed medical board mechanism at the district level, together with statutory immunity provisions modelled on the Dutch due care defence, would reduce both delay and physician reluctance arising from fear of legal liability, while preserving India's insistence on prospective, rather than purely retrospective, verification.

Expansion of Palliative Care Access and Public Awareness: Expansion of palliative care infrastructure, integrated with the National Health Policy's stated commitment to universal access, is essential to ensure that requests to withhold or withdraw treatment reflect genuine, informed choice rather than the absence of adequate pain management. Sustained public health literacy campaigns are equally necessary to close the awareness gap that currently limits use of the advance directive mechanism.

Transparent Retrospective Audit: India should establish a dedicated, publicly accessible review body, analogous in function though not in decisional authority to the Dutch Regional Euthanasia Review Committees, tasked with the periodic, anonymised publication of aggregate data on cases of withdrawal of treatment, to build public confidence and enable evidence-based refinement of the framework over time.

The Limits of Borrowing: What India should not Adopt: Extension of India's regime to active euthanasia, physician-assisted suicide, or euthanasia for minors would require a

distinct and far more contested constitutional and legislative determination, given India's markedly different socio-economic context, disability rights concerns, and the continuing absence of universal, high-quality palliative care access. The recommendations above are accordingly confined to procedural learning from the Dutch experience and deliberately exclude any expansion of India's substantive scope.

CONCLUSION

This comparative study shows that India and the Netherlands, despite sharing a commitment to patient autonomy and human dignity at the end of life, have developed different legal frameworks. India's framework, developed through constitutional interpretation in *Common Cause* (2018), its 2023 procedural simplification, and its first practical application in *Harish Rana* (2026), remains judicially evolved, procedurally cautious, and limited to passive euthanasia. The Netherlands, under the Wtl of 2002, has a legislative and physician-centred framework that is broader in scope, covering active euthanasia, physician-assisted suicide, and eligible minors since 2024. India's framework is an advance from its earlier blanket prohibition but does not fully translate constitutional rights into practical accessibility. Low public awareness, uneven rural healthcare and physician concerns about legal liability make the right to die with dignity more theoretical than practical. Although the Dutch model is procedurally mature and supported by extensive Review Committee data, it cannot be fully transplanted into India because uniform physician competence, strong palliative infrastructure and legislative consensus on active euthanasia are not yet present.

The hypothesis that India's passive euthanasia framework can be strengthened through selective adoption of Dutch procedural safeguards without expanding its substantive scope is supported by this study. Independent second opinions, defined procedural timelines and transparent retrospective review can be adopted without recognising active euthanasia, physician-assisted suicide or euthanasia for minors. India should therefore not replicate the Dutch model but incorporate its procedural strengths into a dedicated statute consolidating the principles developed through *Aruna Shanbaug*, *Common Cause*, the 2023 modification and *Harish Rana*. This would balance the sanctity of life with the constitutional guarantee of dignity.