
LEGALIZING AND REGULATING ASSISTED SUICIDE IN INDIA: A CONSTITUTIONAL ANALYSIS RECONCILING ARTICLE 21 AUTONOMY WITH AN AGE-BASED CONSULTATION SAFEGUARD.

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ABSTRACT

This paper examines whether India should legally allow assisted suicide under a carefully regulated system. Article 21 of the Constitution protects the right to life and has been expanded by the Supreme Court to include dignity, privacy, and personal autonomy. Courts have already recognized passive euthanasia and advance directives, allowing individuals to refuse life-sustaining treatment in certain situations. However, active assisted suicide remains illegal, creating a gap in the law. A person may refuse treatment and allow natural death, but cannot legally seek assistance to end unbearable and irreversible suffering.

The paper argues that India should adopt a limited and phased legalization model that respects autonomy while strongly protecting vulnerable individuals. The main concern with assisted suicide is the risk of impulsive decisions, depression, coercion by family members, financial pressure, or lack of proper medical care. To address these risks, the paper proposes a mandatory consultation period before approval. For senior citizens above 65 years, a one-year consultation period is suggested. For younger age groups, longer waiting periods are recommended. The proposal includes medical evaluation, psychiatric assessment, screening for coercion, and repeated confirmation of consent. It also suggests an independent review board and strict punishment for abuse. Age should not be the only factor; medical urgency exceptions must be included to pass constitutional scrutiny under Article 14.

The goal is not to make assisted suicide easily available, but to create a balanced constitutional framework that protects life while respecting dignity and informed personal choice.

Keywords: Assisted Suicide, Autonomy, Dignity, Procedural Safeguards

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Material and Methods

This study follows a doctrinal legal research methodology. It analyzes constitutional provisions, particularly Article 14 and Article 21 of the Constitution of India, along with relevant Supreme Court judgments on euthanasia, dignity, and end-of-life decisions.

The research relies on primary sources such as constitutional provisions, statutes, and judicial precedents, and secondary sources including Law Commission Reports, academic articles, and NCRB suicide data.

The paper adopts a constitutional and normative analysis approach to evaluate the legality of assisted suicide and to propose a phased, age-based consultation model with procedural safeguards.

The study is limited to legal and constitutional analysis.

1. Introduction

The Indian constitutional imagination has consistently expanded the meaning of life. Article 21, once interpreted narrowly as mere physical existence, now encompasses dignity, privacy, bodily integrity, decisional autonomy, and the right to refuse medical treatment. Yet, the question of whether the “right to life” also includes a limited right to choose death remains one of the most contested moral and legal issues in Indian jurisprudence.

India’s legal position today is complex. While attempted suicide has been substantially decriminalized in practice through legislative reform, active assisted suicide remains unlawful. At the same time, passive euthanasia and advance directives have received conditional judicial recognition. This creates a legal gap: a person may legally refuse life-sustaining treatment in certain circumstances, but cannot legally seek assistance to end life even when suffering becomes unbearable, prolonged, and irreversible.

This paper argues that India must initiate a carefully regulated framework for assisted suicide that respects autonomy under Article 21 while preventing impulsive decisions and safeguarding vulnerable individuals. The most defensible path is a limited, phased legalization beginning with senior citizens and gradually expanding eligibility only after evidence-based review. To address the most pressing concern impulsive suicide a mandatory consultation and review

period is proposed, with a one-year consultation period for senior citizens above 65 years, and longer periods for younger age groups.

The central claim is not that assisted suicide should become a freely available choice. Rather, it should be permitted only through a constitutional model that treats autonomy seriously while placing procedural safeguards strong enough to prevent abuse, coercion, and temporary emotional crises from becoming irreversible death.

2. The Constitutional Foundation: Article 21 and the Right to Choose

2.1 Life as dignity, not mere survival

Indian constitutional law increasingly recognizes that life is not limited to biological existence. The Supreme Court has repeatedly held that dignity is integral to life. The right to privacy, bodily autonomy, and decisional freedom are all treated as Article 21 interests.

If dignity is central, then the State cannot reduce the human being to a mere object of survival. In cases involving medical treatment, the Court has accepted that forcing treatment upon a person may violate dignity. This logically opens the door to a limited argument: if the Constitution protects the dignity of life, it must also recognize dignity at the end of life.

2.2 The tension: sanctity of life vs autonomy

Assisted suicide sits at the intersection of two constitutional values:

- **Sanctity of life:** The State's obligation to protect life and prevent suicide.
- **Autonomy:** The individual's right to make intimate decisions about their body and suffering.

A constitutional framework must reconcile these values, not treat one as absolute. The danger of an autonomy-only approach is that it may enable impulsive death. The danger of a sanctity-only approach is that it may compel prolonged suffering without meaningful purpose.

The Indian constitutional structure is built around balancing. Therefore, a middle path is the most realistic and legally sustainable.

3. India's Current Legal Position: A Partial Recognition Without a Complete Framework

India currently recognizes certain end-of-life choices indirectly, but does not allow active assistance to die.

3.1 Suicide and its decriminalization trend

Attempted suicide is no longer treated as a purely criminal act in modern policy thinking. The shift reflects recognition that many suicidal acts arise from distress, mental illness, or unbearable suffering. This reform is relevant because it demonstrates that the State's approach to suicide is no longer purely punitive.

However, decriminalizing attempted suicide does not automatically legalize assisted suicide. The latter involves third-party participation, which raises risks of coercion, exploitation, and abuse.

3.2 Passive euthanasia and advance directives

Indian courts have accepted passive euthanasia in limited contexts. Advance directives have also been recognized. This means the law already accepts a limited principle: a person may refuse continued medical intervention and allow natural death.

This recognition creates a constitutional inconsistency: if refusing treatment is permitted as an exercise of autonomy and dignity, why must a person endure prolonged suffering when medical withdrawal is not an option or is practically inaccessible?

Assisted suicide can be conceptualized as an extension of the same autonomy principle, but with stricter safeguards due to higher risk.

4. Why Assisted Suicide Requires a Stronger Safeguard Model

The strongest objection to assisted suicide is not moral disagreement. It is fear of irreversible mistakes.

The most common risk factors are:

- **Impulsive decision-making**

- **Temporary depression**
- **Family pressure**
- **Financial exploitation**
- **Undiagnosed treatable mental illness**
- **Social abandonment of elderly persons**
- **Gendered coercion and domestic abuse**
- **Caste-class vulnerability**
- **Lack of palliative care access**

A workable Indian model must directly address these risks. A “cooling-off” period is a constitutionally reasonable safeguard because it protects life without denying autonomy absolutely.

5. Proposed Model: A Phased Age-Based Consultation Framework

5.1 The core proposal

This paper proposes a phased legalization model in which assisted suicide is first permitted only for senior citizens, and later expanded cautiously. The central safeguard is a mandatory consultation period, during which the person’s decision is assessed repeatedly by independent professionals.

The proposed consultation timeline is:

Age at applying	Mandatory consultation period	Slot allocated at age
65	1 year	66
50	4 years	54
40	7 years	47

Age at applying	Mandatory consultation period	Slot allocated at age
30	9 years	39
25	12 years	37

5.2 Why start with senior citizens (65+)?

If India legalizes assisted suicide in a broad, universal form immediately, it will face:

- Strong political resistance
- Moral backlash
- Increased litigation
- High risk of misuse

A limited model for 65+ is more defensible because:

- The probability of chronic, irreversible suffering is higher.
- The risk of impulsive suicide is comparatively lower.
- There is greater likelihood of stable long-term preference.
- It can function as a **pilot**, allowing evaluation and correction.

This approach mirrors the constitutional principle of **incremental reform**.

5.3 The one-year consultation as “fastest” route

A one-year period for 65+ is justified as the fastest route because:

- It is long enough to detect impulsive decisions.
- It allows repeated mental health evaluation.
- It gives time for family counselling and palliative care.

- It prevents the system from becoming a same-day or same-month death mechanism.

The purpose of the one-year consultation is not to delay death for its own sake, but to ensure the decision is stable, voluntary, informed, and free from coercion.

6. Constitutional Problems with Pure Age-Based Waiting Periods (and How to Fix Them)

This is the most important legal section.

A strict age-based waiting period is vulnerable to constitutional attack under **Article 14**, because it creates unequal treatment among adults without a strong rational basis.

For example:

- Why should a 30-year-old with irreversible neurological disease wait 9 years?
- Why should a 50-year-old with terminal cancer wait 4 years?

6.1 The Article 14 test

For a classification to be valid, it must satisfy:

1. **Intelligible differentia** (clear classification)
2. **Rational nexus** with the objective

The objective here is preventing impulsive decisions and protecting vulnerable people.

Age is a proxy for impulsivity, but it is not perfect. The classification can be defended only if it is framed as:

- A **phased implementation**, not a moral judgment
- A **pilot system**, not a final denial
- A **minimum safeguard**, not the only safeguard

6.2 The constitutional repair: add medical urgency exceptions

To make the model legally robust, the law must include a clause:

- If a person suffers from terminal illness or irreversible unbearable suffering, the waiting period may be shortened through a higher-level review board.

Otherwise, the model becomes cruel and irrational.

So, your age-based timeline can remain as the default, but with constitutional flexibility.

7. Consultation Mechanism: What Happens During the Waiting Period?

To prevent the model from becoming symbolic, the consultation period must involve real safeguards.

A legally workable consultation process should include:

1. Medical assessment

- Diagnosis confirmation
- Prognosis and treatment alternatives
- Pain management options

2. Psychiatric evaluation

- Depression screening
- Suicidal ideation vs stable long-term preference
- Capacity to consent

3. Social work review

- Family coercion check
- Financial exploitation check
- Domestic abuse screening

4. Legal counselling

- Informed consent explanation

- Consequences, finality, withdrawal rights
- Documentation and witness process

5. Mandatory palliative care consultation

- To ensure the person is not choosing death due to lack of pain relief

6. Periodic reaffirmation

- Written reaffirmation every 3 months (for 1-year track)
- Every 6 months for longer tracks

The consultation should not be treated as an obstacle course, but as a constitutional due process mechanism protecting both the individual and society.

8. Eligibility: Why It Cannot Be Only Age

If eligibility is only age, the model becomes ethically and legally unstable.

A better legal approach is:

8.1 Primary eligibility (for the pilot)

For the 65+ category, eligibility may be limited to:

- Irreversible illness, disability, or chronic suffering
- or**
- persistent loss of dignity and autonomy that is enduring and medically confirmed

This avoids the criticism that healthy elderly persons may seek assisted suicide due to loneliness, poverty, or neglect.

8.2 Capacity requirement

The person must have:

- mental capacity

- free will
- stable decision over time

If a person is clinically depressed or cognitively impaired, the request must be suspended until treatment and reassessment.

9. Organ Donation: not mandatory but encouraged

9.1 Why mandatory donation is unconstitutional

Forced donation violates:

- bodily autonomy (Article 21)
- consent principle in medical ethics
- dignity principle
- the prohibition on coercion

It could also create a dangerous perception: that the State is incentivizing death to harvest organs.

9.2 A better legal version

Propose:

- **Automatic counselling for organ donation**
- **Strong encouragement and awareness**
- **Opt-in consent during the consultation period**
- **Independent consent verification**

This achieves your policy goal (maximizing donation) without turning it into coercion.

10. Slot Allocation: Applying vs Approval vs Procedure

Your model includes a concept of:

- **Age of applying**
- **Age of slot allocation**

This can be framed as a “registry system.”

10.1 How the registry system could work

- A person applies at age X.
- They enter a supervised consultation period.
- If they remain consistent, they are “allocated a slot” at age X + waiting period.

However, legally, the system must allow:

- withdrawal at any stage
- suspension if coercion or mental illness is detected
- emergency review for terminal cases

Otherwise, it becomes bureaucratic cruelty.

11. Safeguards Against Abuse: The Indian Reality

India has unique risk factors:

- elder abuse and property disputes
- dowry-related violence
- caste discrimination
- poor mental health infrastructure
- uneven healthcare access

- corruption risks

Therefore, safeguards must include:

- mandatory video recording of consent statements
- independent witnesses not related to the beneficiary of inheritance
- strict punishment for coercion, forgery, or facilitation without approval
- audit trails and reporting to a state oversight body
- periodic public reporting (without revealing identities)

12. Counter-Arguments and Rebuttal

12.1 “This will normalize suicide”

Rebuttal: This model does not normalize impulsive suicide. It creates a long, structured process with repeated evaluations. It treats the decision as exceptional, not casual.

12.2 “The poor will choose death due to poverty”

This is a serious objection. The rebuttal must be honest:

- Assisted suicide cannot become a substitute for welfare.
- The law must require proof that the decision is not driven primarily by poverty or abandonment.
- The State must expand palliative care and elder support simultaneously.

12.3 “Families will push elders to die”

This is why the consultation process must include:

- coercion screening
- inheritance conflict checks

- independent witness requirement
- criminal penalties for pressure

13. Recommendations for a Legally Sustainable Indian Model

A strong Indian model should include:

1. **Pilot legalization for 65+ with 1-year consultation**
2. **Independent Medical-Legal Review Board**
3. **Mandatory mental health and palliative care evaluation**
4. **Phased expansion with longer waiting periods**
5. **Medical urgency exception**
6. **Opt-in organ donation counselling**
7. **Criminal penalties for coercion and forgery**
8. **Transparent reporting and oversight**

14. Conclusion

Data for suicides in India in 2025 is not yet available, as official figures from the National Crime Records Bureau (NCRB) are typically released with a delay. As of the latest available data, there were 171,000 recorded suicides in 2022, marking a 4.2% increase over 2021.

There is more to assisted suicide than just a moral argument. What dignity, autonomy, and state responsibility mean is a constitutional question. India's current stance acknowledges dignity at the end of life through advance directives and passive euthanasia, but it still denies people a limited right to ask for help to end their lives, even in situations where their suffering is unbearable and irreversible.

This paper suggests a compromise: a framework for phased assisted suicide that is based on Article 21 autonomy but is protected by stringent procedural safeguards. A mandatory

consultation period aimed at preventing rash decisions is the most important safeguard. With longer consultation periods for younger age groups, the model suggests the quickest track one year for seniors over 65.

However, the model cannot rely only on age to pass constitutional scrutiny. Coercion protections, urgency exceptions, and medical and mental health requirements must all be included. In a similar vein, organ donation can be strongly encouraged through organized consent procedures but cannot be made mandatory.

In the end, the constitutional guarantee of dignity cannot be fulfilled in the final years of suffering or at the hospital door. In addition to protecting life, a humane legal system must respect each person's right to make important decisions when life becomes an endless burden. The goal of the law is to create a framework that upholds autonomy, prevents coercion, and preserves dignity rather than to impose death or suffering.

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