International Journal of Social Science Research and Review

http://ijssrr.com
editor@ijssrr.com
Volume 8, Issue 8
August, 2025
Pages: 238-247

Ethics of Legalization of Euthanasia in the Indian Context

Kaavya Mukherjee Saha

New Delhi, India

Email: kaavyamukherjeesaha@gmail.com

http://dx.doi.org/10.47814/ijssrr.v8i8.2859

Abstract

Euthanasia remains one of the most ethically and spiritually contested issues in modern healthcare. This paper explores the multifaceted ethical debates and religious perspectives that shape global and regional attitudes toward euthanasia, with a particular focus on India. Ethically, euthanasia raises critical questions about autonomy, dignity, and the role of medical professionals in end-of-life care. While proponents argue for the right to die with dignity and relief from unbearable suffering, opponents cite the sanctity of life, potential for coercion, and the slippery slope toward non-voluntary euthanasia. Religious traditions significantly influence these views. Hinduism and Buddhism, though varied in interpretation, often discourage euthanasia due to beliefs in karma and the spiritual importance of natural death. Christianity and Islam largely oppose euthanasia, citing divine sovereignty over life and death. In contrast, some secular ethical frameworks prioritize individual rights and quality of life. The paper also considers how these religious and moral tensions impact legislation and access to palliative care, particularly in resource-strained settings. Ultimately, understanding the ethical and spiritual dimensions of euthanasia is essential for shaping compassionate and culturally sensitive healthcare policies that respect both patient autonomy and deeply held beliefs.

Keywords: *Euthanasia; Assisted Suicide; Bioethics; Religion; Class*

Introduction

Euthanasia has been surrounded by debates for a long time, raising complex ethical and sociological questions. It involves intentionally ending a life to alleviate suffering, often at the explicit request of the patient, as seen in voluntary euthanasia and assisted suicide. While some argue that they honor individual autonomy and offer a dignified end for suffering patients, opponents talk about the importance of life and potential for misuse, especially in vulnerable populations.

The word ‘Euthanasia’ is derived from Greek, ‘Eu’ meaning ‘good’ and ‘thanatos’ meaning ‘death’, put together it means ‘good death’. Euthanasia is defined as the hastening of death of a patient to prevent further sufferings. Active euthanasia is the deliberate act by a physician to terminate the life of a patient suffering from an incurable or terminal illness. The most common mode of this is the introduction of lethal drugs to the patient’s system. Passive euthanasia, on the other hand, refers to withholding or withdrawing treatment which is necessary for maintaining life.

There are three types of active euthanasia, with respect to giving consent for euthanasia, namely voluntary euthanasia – at patient request, nonvoluntary – without patient consent, involuntary euthanasia – patient is not in a position to give consent [1]. Physician-Assisted suicide refers to ‘writing a prescription for a lethal dose of medication (“lethal prescription”) that a terminally ill patient intends to use to end his or her life [2].

Countries around the world present different cases of study. In Russia, all forms of euthanasia are illegal. In the United Kingdom, much like India, passive euthanasia is legal but active euthanasia and assisted dying are strictly illegal. In the federal set up of the United States, some states (California, Colorado, Hawaii, Montana, Maine, New Jersey, New Mexico, Oregon, Vermont, and Washington) allow active euthanasia while passive euthanasia is legalised everywhere [2]. In countries like New Zealand, the Netherlands, and Belgium, all forms of euthanasia are legal. In the Netherlands, physicians have the right to refuse to carry out euthanasia, even if all conditions set by the government are fulfilled. In cases such as the Schoonheim case, in 1984, the physician’s duty to relieve suffering overpowered the duty to alleviate suffering.

India presents a unique context for examining these practices. The Supreme Court's landmark judgment in the Aruna Shanbaug case introduced passive euthanasia under strict guidelines, bringing the discourse to the forefront of public and professional attention [3]. However, the debate has a unique place in the Indian context, as India often faces underfunding in the healthcare system and has a diverse array of cultural views. Many believe that euthanasia is susceptible to coercion - from family, society, or systemic inadequacies - while others believe that the patient should have a choice in the matter [4].

From a sociological perspective, medical ethics, power dynamics in doctor-patient relationships, the role of religion in shaping societal norms, and its relations to kinship can be interesting fields of study. I also want to explore the impact of socio-economic disparities on end-of-life decisions. Poor access to healthcare, lack of mental health services, and stigma surrounding conditions like depression can shape an individual's request for assisted dying.

The research aims to fill a gap in the existing literature on euthanasia by examining the intersection of ethics, socio-economic status, and religion within the specific cultural and healthcare context of India. While global debates around euthanasia have largely centered on bioethics, there is a lack of nuance that looks at how religious affiliation, caste, and class influence attitudes toward end-of-life decisions.

Thus, this research seeks to explore several questions surrounding the ethics of euthanasia, particularly in the Indian context.

Research Question 1 - Should the state have the authority to ban euthanasia, considering principles of autonomy and individual rights?

Research Question 2 – How does religion and class influence the likelihood of individuals opting for euthanasia, exploring whether specific religious beliefs and class dynamics correlate with attitudes toward end-of-life decisions?

Religion

In predominantly Christian societies, as seen in the US or in the UK, there is an emphasis on the sanctity of life. This view gives weight to the single human life - and decrees it inalienable. As our Right to Life is inalienable, it is not within our control to manipulate, and is considered sacrilege of a gift of God. The Catholic church also delineates the religious principle of divine sovereignty, where only God is considered Lord over life and death [5]. Similarly, Islam forbids euthanasia as human beings should not interfere with the lease of life Allah has given them. Judaism similarly does not permit euthanasia or physician-assisted-suicide. Despite the emphasis on the sanctity of life, none of these religions insist upon the duty to ward off death, but rather stress the absence of interference from 'God's plan' or divine will. Most religions find passive euthanasia permissible, but are against active euthanasia. There is similarly an emphasis on intention, wherein a treatment that may kill someone is permissible insofar as the intent of it is not to end the patient's life [6].

Opponents to active euthanasia claim that it is "playing God". Presumably this means that by interfering with the natural progression of a patient's condition, a doctor practicing euthanasia is exercising a certain power over life and death that only God should have. This accusation is countered, however, by the simple fact that a doctor interferes with the natural progression of a patient's disease every time he provides him with treatment [7].

Other religions may take a more nuanced view or have different reasoning. Religions such as Hinduism view euthanasia as a disruption of the karmic cycle. Furthermore, a tenet of Hinduism is 'ahimsa,' or non-violence. Violence towards one self is seen as violation of the universal principle of ahimsa. However, often the act of 'mercy killing' or assisted suicide is seen as a compassionate act which may help another gain karma or achieve spiritual understanding [8]. Buddhism too views 'compassion' as a legitimate reason to assist in suicide, but still maintains that it is immoral to harm another individual.

However, the practice of fasting to death (*prayopavesa* in Hinduism and *santhara* in Jainism) is seen as acceptable. Although this is voluntary in nature, it is seen as a gradual process which allows the body to prepare for death in order to achieve spiritual peace. Suicide and/or euthanasia tend to have connotations of 'frustration, aggression, and depression.' Fasting is seen as natural and non-violent - done only when an individual is at peace with themselves.

Therefore, it can be construed that religion has an effect on who opts into euthanasia. Research has shown that "being politically liberal, not being religious, and attending religious services infrequently are associated with agreement with legalization" [9].

Class

India's healthcare infrastructure is disproportionately concentrated in urban areas. While only 27% of the population resides in cities, these areas are served by approximately 75% of the nation's health facilities [11]. This imbalance results in a significant disparity in access to palliative and end-of-life (EoL) care services. One study observed that existing palliative care programs are predominantly urban-based and are often attached to tertiary hospitals [10] leaving rural populations with limited or no access to such essential services. In some instances, rural patients must travel over 100 kilometers to reach a suitable healthcare facility. This issue is further compounded by the fact that the estimated palliative care need in rural India is more than double as observed in urban areas [11].

The economic strain of end-of-life care is substantial and is disproportionately borne by rural households. Data indicate that rural families pay approximately 92% of hospitalization costs out-ofpocket, compared to around 77% for urban families. Moreover, a larger percentage of rural households in India fall into or deeper into poverty due to medical expenses, compared to urban households [12].

This financial vulnerability is exacerbated in the absence of legal euthanasia, as families are often compelled to continue costly and futile treatments. Healthcare professionals have noted that terminal care often leads to catastrophic expenditures, which in turn drives some support for legalizing euthanasia in India [13]. For families without insurance or subsidies, conditions more common in rural areas, the financial strain becomes particularly acute.

Furthermore, access to essential pain-relief medications is limited outside urban centers, and few medical institutions incorporate pain management training in their curricula. Consequently, most terminally ill rural patients die at home without adequate symptom relief. It is estimated that 70–80% of rural cancer patients never even reach a hospital in their final stage of illness [10].

Family members, particularly women, provide the vast majority of chronic care for terminally ill patients in India, with over 90% of such patients living at home [13]. The burden placed on caregivers is immense. A study measuring caregiver stress using the Zarit Burden Interview found average scores near 20 (out of 40), reflecting moderate to high stress levels. Caregivers below the poverty line reported even higher burden levels. While both rural and urban caregivers experience significant stress, those in rural areas generally have fewer avenues for institutional support.

Given this data, it can be seen that the continuance of treatment due to lack of option of euthanasia exhibits a severe and disproportionate strain on those living in rural areas and in poverty in India. As caregiver burnout and shortage of workers is more common in rural areas, we can see that patients in these areas that are compelled to continue medical treatment and expenses continue to suffer in worse conditions for longer periods of time.

Ethical Dilemmas

There are certain ethical dilemmas also attached to this highly contested practice. The four principal tenets of bioethics are autonomy, beneficence, non-maleficence and justice [14]. The concept of *autonomy* is defined in various contexts through several perspectives,

> “Put most simply, to be autonomous is to govern oneself, to be directed by considerations, desires, conditions, and characteristics that are not simply imposed externally upon one, but are part of what can somehow be considered one’s authentic self” [15].

Informed consent on the other hand refers to:

> “The fundamental idea that we aim to capture when we claim that ‘A morally ought to obtain B’s informed consent to A’s doing x to B’, is that the moral permissibility of A’s doing x to B, is at least partly dependent on the following conditions being met:
>
> (i) *B* must be sufficiently informed with regards to the relevant facts concerning *x* to understand what *x* is (and what consequences are likely to occur as a result of *x*).
>
> (ii) On the basis of this information, *B herself* makes the decision to allow *A* to do *x*” [16].

In the case of euthanasia, a patient must be presented with all information about their illness and related treatment for the principle of autonomy to be applicable. Only then can patients opt for any form of euthanasia in an autonomous manner. Furthermore, physicians are obligated not to disclose confidential information given by a patient to another party without the patient's authorization [14]. As per self-governance, the capacity and competence of patience is a grounding criterion.

> “On the requirements of self-rule, it can be claimed that to govern oneself one must be in a position to act competently based on desires (values, conditions, etc.) that are in some sense one’s own. This picks out the two families of conditions often proffered in conceptions of autonomy: competency conditions and authenticity conditions. Competency includes various capacities for rational thought, self-control, and freedom from debilitating pathologies, systematic self-deception, and so on. Authenticity conditions often include the capacity to reflect upon and endorse (or identify with) one’s desires, values, and so on” [15].

A strong emphasis on autonomy has led to a shift in viewing patients not as passive recipients of care, but as active agents in their own healthcare decisions. This shift also fosters skepticism toward any form of manipulation or paternalism that may influence a patient’s choices. For individuals to truly exercise autonomy, they must possess the capacity for rational thought and be free from debilitating mental or emotional conditions. However, this criterion often excludes those most affected in the euthanasia debate—patients receiving end-of-life care—who may not meet these stringent standards due to the nature of their illnesses.

Moreover, autonomy is only meaningful when decisions are made freely, without external pressures. Factors such as religious beliefs or financial hardship can exert a coercive influence, compromising the authenticity of a patient's choice regarding euthanasia.

The assumption that a mentally competent but physically disabled individual should be considered vulnerable, and thus restricted from making autonomous decisions for their own protection, can be seen as a form of moral paternalism. Paternalism, in this context, involves limiting a person’s freedom supposedly for their own good or for the welfare of society at large [17].

The principle of *beneficence* is the obligation of a physician to act for the benefit of the patient and supports a number of moral rules to protect and defend the right of others, prevent harm, remove conditions that will cause harm, help persons with disabilities, and rescue persons in danger. It is worth emphasizing that, in distinction to nonmaleficence, the language here is one of positive requirements. The principle calls for not just avoiding harm, but also to benefit patients and to promote their welfare. Beneficence has enjoyed a historical role in the traditional practice of medicine. However, giving it primacy over patient autonomy is paternalism that makes a physician-patient relationship analogous to that of a father/mother to a child [18].

“Voluntary euthanasia or assisted suicide can be legalised on the grounds of beneficence provided that:

(a) that death confers a well-being benefit in the sense that it actualises a comparatively better life course for the patient (ie, a shorter life with less net suffering),

(b) that death is beneficial because non-existence which entails no suffering is superior to an existence filled with suffering” [19].

However, what is more likely found is that beneficence works against the principle of autonomy to criminalise euthanasia and assisted suicide, specifically because the disruption of life or death is viewed as ‘leaving an individual worse off.’ Coupled with the religious taboos associated with euthanasia, which would not permit the idea that death is beneficial over life, beneficence has a more central role in the legal framework surrounding euthanasia, corroborated by its already historical standing in bioethics.

The principle of *nonmaleficence* asserts that "a doctor ought not to inflict evil or harm or bring his patients into the risk of evil or harm." Patients who receive treatments that take a tremendous physical toll upon them, treatments which neither adequately combat the pain of their conditions nor provide a cure, simply endure a prolonged period of pain and suffering. Similarly, patients who decide to withdraw such treatment but who do not have the option of euthanasia are left to die in perhaps even more excruciating pain because of the extra toll that the combined effects of their illnesses and past treatments take upon them [7]. Therefore, by the principle of non-maleficence, one can argue that the lack of opting-in to euthanasia leaves patients with unnecessary suffering, meaning voluntary active euthanasia should be legalised.

The principle of *justice* can be thought of as expressing "fair, equitable, and appropriate treatment in light of what is due or owed to persons." Justice is primarily concerned with equal treatment and morally permissible action. One of the arguments that has monopolised the debate concerning assisted dying is the ‘slippery slope’. According to this, should assisted suicide be established, then it might be applied in circumstances that fall outside the scope of morally permissible cases, such as in patients who may not be fully competent. Furthermore, if a person is motivated by means other than his own will, for example through external coercion, then patient autonomy is infringed [20].

Within the framework of this principle, we can see that people from lower classes are more likely to opt into euthanasia due to financial pressures from continuation of treatment. Figures have consistently shown that a disproportionate number of requests for assisted suicide and euthanasia have come from poorer sections of society [21]. External coercion could manifest as financial pressure due to lack of insurance or familial pressure to end payment for end-of-life care, causing patients to opt into euthanasia but violating the principle of justice simultaneously, as there is little equality upheld.

On the other end of the spectrum, we see that those who are religious are more likely to not opt into euthanasia [22]. Assuming freedom of religion and freedom of economic choices, we must accept that the autonomy principle trumps the violation to the principle of justice, as patients concerned about finances retain the autonomy to make finance-conscious decisions, in a similar way as to how religious patients retain the autonomy to refuse treatment (passive euthanasia) or opt out of euthanasia.

State and Paternalism

Paternalism, it might be claimed, is based on a traditional medical model of a relationship between the doctor and the patient, one that is incompatible with the more modern approach of patient-centered care.

The justifications of paternalism are as follows:

1. Protection from harm: In many ways, this is the easiest justification for paternalism. If we adhere to the notion that we generally ought to avoid doing things that could result in serious harm to ourselves – say through our own rash, imprudent, uninformed choices – and if we think that some patients are not capable of forming the complex understandings that would render their choices informed, then in those instances we can give the detectives a break.

2. Best interest: Nowhere is medicine’s paternalistic origins more blatant than when physicians invoke acting in the patient’s best interest, an idea most often invoked when their patients lose their capacity to make their own decisions.

In India, we can see that the state has adopted a heavily paternalistic standpoint. The Indian law places the sanctity of life, given that death is permanent, irreversible and greatly affecting, above the principle of autonomy.

Paternalism is often preferred due to the practicality and efficiency in which it can uphold principles of protection and justice.

“The reality of the matter is that we expect the physician to (1) do a thorough history and do a thorough and complete physical examination on each patient; (2) speak to them about the diagnosis, prognosis, and options of treatment; (3) explain and encourage them to execute an advance directive making sure that they understand what they request or refuse; (4) treat the patient as a person – not just as a disease complex; (5) where indicated fill out a prescription or a referral slip; (6) keep a careful record of what was said and found [23].”

To follow these steps is not only tedious, but is unlikely to happen. Countries like the Netherlands or New Zealand, where euthanasia has been somewhat successfully legalised [24], are much smaller, sparsely populated, and richer than India. Levels of literacy and resources to ensure this happens are much lower in India. It cannot be ensured that in a crowded rural hospital where doctors are overworked and facilities are largely unavailable [25], such thorough and meticulous obtention of consent will be carried out.

As class and religion markers play a huge role in end-of-life care, it is also debatable whether the consent received is genuine. To ensure the consent is genuine, the requirements for the consent are delineated as follows:

- Competency Assessment: Among the most pressing practical challenges is to interpret a patient’s competence to consent, particularly when he or she is in severe pain, has a terminal illness, or has cognitive impairment.

- Documentation and Witnessing: With the requirement that consent for euthanasia have to be documented and witnessed, that too needs to be formalized. The Indian judiciary has carried out the passing of Acts – like the Maharashtra Clinical Establishments (Regulation of Advertising and Registration) Act, 2008 – which goes a certain way in imposing the need for medical practitioners to record and verify aspects of a doctor-patient relationship, but there is no overarching legislation that outlines these protocols, and therefore no framework in which to interpret consent.

- Revocation of consent: It must provide for revocation of consent, especially with respect to the more widely used method of expression, the living will or advance directive. Revocations must themselves be simple and easy to use, so that patients’ wishes for end-of-life care can be changed as often as they wish, should they wish [26].

The unattainability of these measures is evident, especially within the public healthcare systems in India. Members of lower socio-economic classes in rural areas are the majority of the patients in public hospitals in India, and are most adversely affected by the lack of choice in euthanasia. The problems are as such, respectively:

1. The patient’s competency cannot be assessed through unambiguous means. The mode of assessment, nature of assessor and quality of assessment are all confounding factors in this evaluation. Furthermore, patients suffering from terminal illness will likely not match stringent

assessment guidelines as many present with mental illnesses, severe pain and cognitive impairment [27].

2. The resources for this consistent documentation and witnessing may also be an issue, as time and means to conduct this documentation in an appropriate manner are lacking in a majority of the public healthcare system.

3. Revocation of consent, insofar as death is permanent and irreversible, cannot be extended beyond a limited scope. The revocation of consent therefore only works within the time-frame of a patient consenting to euthanasia to the administering of euthanasia.

An oft-cited argument against euthanasia is the slippery slope argument. Slippery slope arguments posit that if euthanasia is legalised, then the moral guiding principles become blurred, leading to other actions that are morally impermissible to become normalised, or for the restrictions surrounding euthanasia to become more permissive, facilitating abuse. The slippery slope argument fails on two main grounds: first, that the slippery slope is difficult to demonstrate. Many cite the case of the Netherlands, which, upon legalising euthanasia, have steadily loosened their laws surrounding the practice. However, it cannot be demonstrated that the Netherlands has significantly crossed any moral boundary as such, rather the Netherlands has simply expanded access to euthanasia and related practices. The second failure of the slippery slope argument lies in the very root of its genesis: the assumption that the legalisation of euthanasia is illegal. From this point forth, euthanasia can be correlated with a ‘noxious slippery slope’ where the first immoral activity leads to a host of further immoral and further dangerous allowances. However, if one operates with the assumption that euthanasia is not inherently immoral, the argument is refuted, as expanding access to euthanasia and related practices is not seen as negative. Finally, the scope of the ‘abuse’ argument does not have a strong enough mechanism to justify itself: the abuse of a right is no grounds on which to withhold the right, but rather to better mechanisms by which you can curb said abuse. In most countries, the guaranteed rights that a citizen holds have potential to be abused, including the Fundamental Rights of speech, religion, and property, but that reason is not a suitable justification to withhold said rights [28].

This paper is concerned with a theoretical understanding of Euthanasia in the Indian context. In the future, this research would be strengthened by empirical studies and by building further understanding of the Indian context.

Conclusion

In conclusion, the conflict between autonomy and paternalism is central to the euthanasia issue. While the ethos of autonomy supports the concept of individual freedom to decide matters of their lives and deaths, practical and ethical difficulties frequently nullify this idealization—especially in the case of terminal illness. The imposition of competency standards as well as the existence of coercive social forces muddle the genuineness of consent. Concurrently, appealing to paternalism on behalf of protection threatens to disenfranchise those who are mentally competent to make knowledgeable decisions. A more balanced approach is needed—one that honors individual agency but also sees the structural inequalities and vulnerabilities that can inform end-of-life choices. Only from such balance can genuinely compassionate and equitable healthcare policy be achieved.

Bibliography/References

[1] Annadurai, K., Danasekaran, R., & Mani, G. (2014). *Euthanasia: Right to die with dignity*. *Journal of Family Medicine and Primary Care*, 3(4), 477–478. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4311376/

[2] Srivastava, V. (2014). *Euthanasia: A regional perspective*. *Annals of Neurosciences*, 21(3), 81.

[3] Kumari, P. (2024). *Dying with dignity: The legal and ethical dimensions of passive euthanasia in India*. *European Economic Letters*, 14(4), 1271–1282. https://doi.org/10.52783/eel.v14i4.2256

[4] Sinha, V., Basu, S., & Sarkhel, S. (2012). *Euthanasia: An Indian perspective*. *Indian Journal of Psychiatry*, 54(2), 177. https://doi.org/10.4103/0019-5545.99537

[5] Gula, R. M. (1987, December 1). *Euthanasia: A Catholic perspective*. *PubMed*. https://pubmed.ncbi.nlm.nih.gov/10285411/

[6] Grove, G., Lovell, M., & Best, M. (2022). *Perspectives of major world religions regarding euthanasia and assisted suicide: A comparative analysis*. *Journal of Religion and Health*, 61(6), 4758–4782. https://doi.org/10.1007/s10943-022-01498-5

[7] Spina, B. (1998). *Ethical justifications for voluntary active euthanasia*. *Richmond Journal of Law & Public Interest*, 3(1), 71–80. https://scholarship.richmond.edu/jolpi/vol3/iss1/6

[8] Nimbalkar, N. (2007). *Euthanasia: The Hindu perspective*. In *Proceedings of the National Seminar on Bio Ethics*.

[9] Mangino, D. R., Bernhard, T., Wakim, P., & Kim, S. Y. (2021). *Assessing public's attitudes towards euthanasia and assisted suicide of persons with dementia based on their advance request: An experimental survey of US public*. *The American Journal of Geriatric Psychiatry*, 29(4), 384–394. https://doi.org/10.1016/j.jagp.2020.07.013

[10] González, D., & Martínez, J. L. (2021). *Active and passive euthanasia: Current opinion of Mexican medical students*. *International Journal of Environmental Research and Public Health*, 18(3), 1–9. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7854974/

[11] DocBox. (2024, September 23). *Healthcare access in rural India*. https://docboxmed.com/healthcare-access-in-rural-india/

[12] Chandra, A., Debnath, A., & Nongkynrih, B. (2023). *Palliative care need in India: A systematic review and meta-analysis*. *Indian Journal of Palliative Care*, 29(4), 375–387. https://pubmed.ncbi.nlm.nih.gov/38058486/

[13] Ahmad, F., & Mohanty, P. C. (2024). *Incidence and intensity of catastrophic health expenditure and impoverishment among the elderly: An empirical evidence from India*. *Scientific Reports*, 14(1), 15908. https://www.nature.com/articles/s41598-024-55142-1

[14] Han, L., Wang, Y., Hu, K., Tang, Z., & Song, X. (2020). *The therapeutic efficacy of Huashi Baidu formula combined with antiviral drugs in the treatment of COVID-19*. *Medicine*, 99(42), e22715. https://doi.org/10.1097/md.0000000000022715

[15] Stanford Encyclopedia of Philosophy. (2020, June 29). *Autonomy in moral and political philosophy* (Fall 2020 ed.). https://plato.stanford.edu/archives/fall2020/entries/autonomy-moral/

[16] Varkey, B. (2020). *Principles of clinical ethics and their application to practice*. *Medical Principles and Practice*, 30(1), 17–28. https://doi.org/10.1159/000509119

[17] Varkey, B. (2021). *Principles of Clinical Ethics and Their Application to Practice*. *Medical Principles and Practice*, 30(1), 17–28. https://doi.org/10.1159/000509119

[18] Draghici, C. (2015). *The blanket ban on assisted suicide: Between moral paternalism and utilitarian justice*. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2694087

[19] Panayiotou, P. (2023). *Beneficence cannot justify voluntary euthanasia and physician-assisted suicide*. *Journal of Medical Ethics*, 50(6), 384–387. https://doi.org/10.1136/jme-2023-109079

[20] Pugh, J. (2020). *Informed consent, autonomy, and beliefs*. In *Autonomy, Rationality, and Contemporary Bioethics*. NCBI Bookshelf. https://www.ncbi.nlm.nih.gov/books/NBK556864/

[21] Fontalis, A., Prousali, E., & Kulkarni, K. (2018). *Euthanasia and assisted dying: What is the current position and what are the key arguments informing the debate? Journal of the Royal Society of Medicine*, 111(11), 407–413. https://doi.org/10.1177/0141076818803452

[22] Tran, M., Honarmand, K., Sibbald, R., Priestap, F., Oczkowski, S., & Ball, I. M. (2021). *Socioeconomic status and medical assistance in dying: A regional descriptive study*. *Journal of Palliative Care*, 37(3), 359–365. https://doi.org/10.1177/08258597211053088

[23] Berens, N., Wasserman, D., Wakim, P., Bernhard, T., & Kim, S. Y. H. (2022). *Resource limitation and 'forced irremediability' in physician-assisted deaths for nonterminal mental and physical conditions: A survey of the US public*. *Journal of the Academy of Consultation-Liaison Psychiatry*, 63(4), 302–313. https://doi.org/10.1016/j.jaclp.2021.12.010

[24] Loewy, E. H. (2005). *In defense of paternalism*. *Theoretical Medicine and Bioethics*, 26(6), 445–468. https://doi.org/10.1007/s11017-005-2203-0

[25] Rietjens, J. A. C., Van Der Maas, P. J., Onwuteaka-Philipsen, B. D., Van Delden, J. J. M., & Van Der Heide, A. (2009). *Two decades of research on euthanasia from the Netherlands: What have we learnt and what questions remain? Journal of Bioethical Inquiry*, 6(3), 271–283. https://doi.org/10.1007/s11673-009-9172-3

[26] Rajoria, S., & Khan, H. (2024). *The role of consent in euthanasia: Autonomy vs. paternalism*. *International Journal of Law, Management and Humanities*, 7(3), 874.

[27] Jayasheela, N., Dinesha, P. T., & Hans, V. B. (2008). *Financial inclusion and microfinance in India: An overview*. *FinDev Gateway*. https://www.microfinancegateway.org/paper/2008/01/financial-inclusion-and-microfinance india overview

[28] Block, S. D. (2006). *Psychological considerations, growth and transcendence at the end of life: The art of the possible*. *JAMA*, 295(24), 3023–3031. https://doi.org/10.1001/jama.295.24.3023

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