ON ADVANCE DIRECTIVES AND ATTORNEY AUTHORISATIONS – AN ANALYSIS OF THE JUDGMENT OF THE SUPREME COURT IN *COMMON CAUSE (A REGD. SOCIETY) V. UNION OF INDIA*

- Vini Singh*

"Life sans dignity is an unacceptable defeat and life that meets death with dignity is a value to be aspired for and a moment for celebration."

- *Dipak Misra C.J.I.*

ABSTRACT

With the march of law, the concept of 'individual autonomy' has gained much significance. It has been recognized as an essential aspect of human dignity across various jurisdictions. The Supreme Court of India has also rooted it very firmly in the guarantee to life and personal liberty under Article 21, through the privacy-dignity-autonomy matrix propounded in the Puttaswamy judgment.

The recognition of individual autonomy as a facet of Article 21 is likely to have several implications that are already apparent. The recent judgment of the Apex Court in the case of *Common Cause (A Regd. Society) v. Union of India* is an ode to individual autonomy as it has enabled people to draw living wills and attorney authorisations that would be indicative of a person's choice to discontinue treatment if they are in a terminally ill or permanent vegetative state.

Relying on the principle of 'best interest of the patient,' the Court has provided stringent safeguards with respect to the execution of such wills and authorisations, to prevent any possible misuse. Further, by outlining the circumstances in which these wills can be executed, it has also attempted to balance the bioethical and societal concerns regarding euthanasia with individual autonomy. This paper seeks to analyse whether the Apex Court has been successful in its attempt to allay the various concerns regarding passive euthanasia, living wills and attorney authorisations.

INTRODUCTION

The term "euthanasia" is derived from the Greek terms '*eu*,' meaning good and '*thanatos,*' meaning death and pertains to the practice of ending a life to relieve pain and suffering.

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[1] However, the issue of euthanasia is not as simple as the literal translation of the term. The issue is not only contentious, but is also very complex, being one which involves several moral, ethical, societal and economic aspects. It has plagued humankind since ancient times and has occupied the centre-stage on the intersection between bioethics and law.[2]

While proponents of euthanasia bank on the right to self-determination and the futility of prolonging a life without meaning and dignity, the opponents of the practice believe that emphasis must be given to palliative care, and that legalising euthanasia would be violative of the principle of sanctity of life. Therefore, most jurisdictions have attempted to achieve an equilibrium between these viewpoints and have only permitted passive euthanasia i.e. withdrawal of life sustaining measures, with adequate safeguards for persons who are terminally ill or in a permanent vegetative state.[3]In addition to permitting passive euthanasia, many jurisdictions, such as U.K., Canada, Netherlands, Switzerland and Singapore also permit issuance of advance directives with requisite safeguards.[4]

In view of the international jurisprudence, the Supreme Court of India in the case of *Aruna Ramchandra Shanbaug v. Union of India*,[5] upheld the right to die with dignity and permitted passive euthanasia for persons who are terminally ill or in a permanent vegetative state. However, the ruling was silent on the mechanism by which an individual could exercise his/her right to bodily autonomy and express his/her wishes with respect to withdrawal of treatment. The Supreme Court received another opportunity to rule on the matter when a writ petition was filed before it by the NGO, 'Common Cause' seeking guidelines for execution and implementation of advance directives and attorney authorisations, in order to exercise the right to die with dignity.[6]The

[1]Edward J. Gurney, *Is There a Right to Die – A Study of the Law of Euthanasia,* 3 CUMB.-SAMFORD L. REV. 235 (1972).

[2]John D. Papadimitriou et. al, *Euthanasia and Suicide in Antiquity: Viewpoint of the Dramatists and Philosophers,* 100 (1) J.R.Soc. Med. 25-28 (2007).

[3]"Most jurisdictions have allowed passive euthanasia as opposed to active euthanasia which involves an overt act on the part of the physician such as injecting a lethal substance to the patient." Subhash C. Singh, *Euthanasia and Assisted Suicide,* 54(2) JILI 196-231 (2012).

[4] "An Advance Directive is a legal document explaining one's wishes about medical treatment if one becomes incompetent or unable to communicate." Vicki J. Bowers, *Advance Directives: Peace of Mind Or False Security,* 26 Stetson L. Rev. 678 -725 (1996).

[5] (2011) 4 SCC 454.

[6](2018) 5 SCC 1

Court upheld the said right in view of its ruling in the case of *Justice K.S. Puttaswamy v. Union of India*[7], wherein it explored the interrelationship between privacy, dignity and autonomy, and grounded the same in Article 21. Further, in order to prevent the misuse of these directives and authorisations by family members or physicians, the Court has issued detailed guidelines for their implementation and execution. This paper is an attempt to examine the issue of euthanasia in view of this judgment of the Apex Court and to analyse the guidelines issued in the same.

BACKGROUND TO THE JUDGMENT

The issue as to whether the right to die forms a part of the guarantee under Article 21 was first raised before the Apex Court in *P. Rathinam v. Union of India*[8], wherein a constitutional challenge was raised to Section 309 of the Indian Penal Code, 1860 ["**IPC**"], i.e. attempt to commit suicide. Relying on the judgment of *Maruti Shripati Dubal v. State of Maharashtra*[9], the Court held that since fundamental rights have both positive and negative content, the right to life would include the right to die and therefore, Section 309 of the IPC was unconstitutional.

Thereafter, in *Gian Kaur v. State of Punjab*[10], a challenge was raised to the constitutionality of Section 306 of the IPC, i.e. abetment to suicide. Herein, relying on *P. Rathinam*[11], it was argued that abetment to suicide could not be penalised as the abettor was only assisting in enforcement of a fundamental right. The Court set aside its ruling in *P. Rathinam*[12] and opined that all fundamental rights are not the same and hence the same standard must not be applied to them. Therefore, while the guarantees under Article 19 have a negative component,Article 21 cannot be read in a similar manner. Further, even if Article 21 is interpreted in such a fashion, suicide could notbe treated as a part of it, as it always involves an overt act by the person committing suicide. Thus, an unnatural termination of life could not be treated as a part of the right to life.

[7] *Justice K.S. Puttaswamy v. Union of India*(2017) 10 SCC 1, ['Puttaswamy'].

[8] *P. Rathinam v. Union of India*AIR 1994 SC 1844.

[9] *Maruti Shripati Dubal v. State of Maharashtra*(1986) 88 BOMLR 589.

[10] *Gian Kaur v. State of Punjab* (1996) 2 SCC 648.

[11] See *supra* note 9.

[12] *Id.*

However, the Court referred to the judgment of the House of Lords in *Airedale N.H.S. v. Anthony Bland*[13] and distinguished between "right to die" and "right to die with dignity". When a person is in permanent vegetative state or in a terminally ill state, the natural progression of death has already begun and death, without life support technology, is inevitable.

Thereafter, in *Shanbaug*[14], the Court, for the very first time, dealt with the issue of permitting euthanasia. Aruna Shanbaug was a nurse in KEM hospital, Mumbai when she was brutally raped and sustained injuries that left her in a permanent vegetative state. She was cared for by the hospital staff and nurses over a very long period of time, however there was no improvement in her condition. Pinki Virani, a social activist, filed a writ petition on her behalf seeking permission for euthanasia for Aruna Shanbaug, however, it was held that she had no locus to file the petition as she could not be given the status of a next friend. However, the two-judge bench proceeded to rule on the issue, and relying again on *Airedale*[15] and other international jurisprudence, it held that passive euthanasia may be allowed for terminally ill patients or patients in a permanent vegetative state provided that certain safeguards are followed. Recognising the autonomy of the patient, the Court held that if the patient is conscious and capable of giving consent, his or her opinion must be taken, otherwise at least the opinion of a next friend is required, who should decide as the patient would have. The matter would then go to the High Court, where a division bench would be required to constitute a board of three competent doctors to examine the patient. It further held that these guidelines should be followed till the Parliament legislates on the matter.

A BRIEF OUTLINE AND ANALYSIS OF THE JUDGMENT IN COMMON CAUSE V. UNION OF INDIA

I. Analysis of the concept of Euthanasia by the Bench

The issue of right to die with dignity was raised again before the Apex Court by an NGO, Common Cause, through a writ petition seeking legalisation of "advance directives and attorney authorisations" in order to enable people who are terminally ill and/or in permanent vegetative state, to exercise the right to die with dignity. The matter was referred from a three -judge bench

[13] *Airedale N.H.S. v. Anthony Bland*[1993] A.C. 789.

[14] See *supra* note 5.

[15] See *supra* note 14.

to a five-judge bench comprising Dipak Misra C.J., A.M. Khanwilkar, D.Y. Chandrachud, A.K. Sikri and Ashok Bhushan J.J.

The bench has derived the right to die with dignity from the privacy-autonomy-dignity matrix within the guarantee under Article 21 as expounded by the nine-judge bench of the Apex Court in *Puttaswamy.*[16]It upheld the right of an individual, who is capable of consent, to issue "advance directives and attorney authorisations" to allow for withdrawal of futile treatment or life support technology, if the patient is terminally ill or in a permanent vegetative state. [17]Additionally, the bench has issued guidelines in order to prevent any possible misuse of such directives and provided the manner in which such directives may be executed in order to ensure a balance between law and bioethics. [18]

All the judges have analysed the moral, ethical and jurisprudential issues regarding the concept of euthanasia and advance directives in significant detail, in order to derive a basis for the right to execute such directives and attorney authorisations. For instance, the opinion by Dipak Misra C.J. for himself & Khanwilkar J., commences with a philosophical discourse on the value of life, and the futility of a life sans meaning and dignity. He has cited various authors, poets and philosophers such as Epicurus, Hemingway and Tennyson, who have propounded the idea that death is not an enemy and in fact, a death with dignity, as opposed to an undignified continuation of life is a cause for celebration. He has also taken note of the societal aspects associated with this issue, such as, the stigma that may attach to doctors who withdraw life support and the possibilities of misuse of such a provision by unscrupulous relatives, thereby highlighting the importance of meticulous drafting of a law regarding advance directives.[19]Similarly, Sikri J. relied upon Gandhian principles, precepts of various religions regarding human dignity, various international instruments and Mill's conception of individual autonomy[20] to derive the right to die with dignity from Article 21. He classifies it as a "hard case"

[16] See *supra* note 7.

[17]See *supra* note 9, at ¶¶187 and 202, 629.5, 629.10.

[18]*Id* at ¶¶197- 203, 508 -509.

[19]*Id* at ¶¶176-179.

[20]JOHN S. MILL, ON LIBERTY, (1859).

as per Dworkin's conception, wherein several lawful choices are available and judicial discretion needs to be exercised in larger public interest.[21]

Further, Chandrachud J. has examined the issue of euthanasia in the context of the interrelationship between science, medicine, ethics and the constitutional principles of individual dignity and autonomy. He has emphasised the need to assess this right not only from an individual perspective but also from institutional, governmental and societal perspectives with a futuristic outlook.[22] Bhushan J. has also adopted a like approach and has traced the origin of the best interest standard, to be applied by medical professionals, in reference to the Hippocratic Oath and writings of Plato, and discussed various religious teachings as well regarding life and death.[23]

Further, all the members on the bench have examined the precedents set out by the Apex Court from *P.Rathinam*[24] to *Shanbaug*[25], in order to uphold the right to die with dignity. To illustrate, Misra C.J. has opined that the Apex Court in its previous rulings had distinguished between the "right to die" and "the right to die with dignity." While the former could not be considered to be a part of the guarantee to life and personal liberty under Article 21, the latter could be derived from it in a limited manner, i.e. only in the form of passive euthanasia and only for terminally ill and/or patients in permanent vegetative state. Likewise, Sikri J. has discussed the various forms of euthanasia and its philosophy, morality and economics in reference to the opinion of the Court in *Shanbaug*.[26] In addition, Chandrachud J. and Bhushan J. have analysed the opinions in *Gian Kaur*[27]and *Shanbaug*[28] to draw out the distinction between the "right to die" and the "right to die with dignity." Further, they have also drawn parallels with the Transplantation of Human Organs and Tissues Rules, 2014[29], that allow advance directives for transplantation of organs and

[21]RONALD DWORKIN, Law's Empire, (1986).

[22]*Supra* note 9, at ¶¶399 and 521.

[23]*Id* at ¶606.

[24]*Supra* note 9.

[25]*Supra* note 5.

[26]*Supra* note 5.

[27]*Supra* note 11.

[28]*Supra* note 5.

[29] § 24, Transplantation of Human Organs and Tissues Act, 1994.

the Mental Healthcare Act, 2017,that recognises advance directives for persons with mental illness and has specified the manner of recording and implementing such a directive, such as informed consent by the maker, the duties of the medical professional, the constitution of a medical review board, the appointment of representatives of the patient and the protection afforded to healthcare professionals. More importantly, the judges have leaned on the judgment in *Puttaswamy,*[30]wherein the Court had propounded the interrelationship between the concepts of dignity, privacy and individual autonomy to set the foundation for this right. They have focused on the concepts of value and quality of life that have been incorporated into our jurisprudence through several decisions of the Apex Court from *Maneka*[31]to *Puttaswamy*[32], to establish the same.

II. Comparative Jurisprudence referred to by the Bench

The bench has heavily employed international jurisprudence on the subject in order to bolster its conclusions. Following the footsteps of the bench in *Shanbaug*[33]*,* all the judges have dissected the ruling of the House of Lords in *Airedale*[34]*,* wherein the House of Lords has considered libertarian as well as utilitarian viewpoints in allowing passive euthanasia for patients in a permanent vegetative state. While ruling on the issue of whether or not to allow withdrawal of life support from a patient in permanent vegetative state, it is opined that, in cases where patients are unlikely to recover and are in such a state that a large number of medical professionals hold the view that prolongation of life is not in the best interest of the patient, then an exception can be made to the principle of sanctity of life. In fact, giving treatment to a patient who does not wish to continue it, and which confers no benefit upon him, would amount to invasive manipulation of such a patient's body. It is also emphasised that to prevent misuse, the opinion of the Court must be sought in cases of any medical disagreement, dispute between next of kin, or a disagreement of next of kin with the medical opinion or absence of next of kin to give consent. Further, it is observed that prolongation of life in such cases as a lose-lose situation and the skill, labour and money that would be utilised in prolonging the life of the patient could be fruitfully employed in improving the condition of other patients, who if treated, may be able to lead a healthy life. However, despite permitting passive euthanasia, it refrained from developing any law

[30]*Supra* note 7.

[31]*Maneka Gandhi v. Union of India,* AIR 1978 SC 597.

[32]*Supra* note 7.

[33]*Supra* note 5.

[34]*Supra* note 14.

with respect to the same and left the question for consideration with the Parliament. Further, reliance has also been placed by the bench on subsequent judgments with respect to assisted dying such as *R (on the application of Pretty) v. Director of Public Prosecutions*[35] that emphasised the utilitarian argument as well as the respect for patient autonomy. In addition, Chandrachud J. and Bhushan J. have considered the provisions of the Mental Capacity Act, 2005 enacted by the British Parliament that contains detailed provisions as to capacity to consent, appointment of guardian and medical opinion. [36]The guidelines propounded by Misra C.J. bear a close similarity with the provisions of this Act and it is interesting to note that the implementation of this Act has resulted into emphasis on better palliative care instead of withdrawal of treatment.

The bench has also extensively discussed the jurisprudence in the United States with respect to the right to refuse treatment and physician assisted suicide. However, the bench has only taken inspiration from the former and rejected the latter. Misra C.J., Chandrachud J. and Bhushan J. have discussed the provisions of the legislations in the States of Oregon, Washington, Montana and Columbia that provide for advance directives and safeguards with respect to their implementation. They have also referred to the decisions of the U.S. Supreme Court in *Cruzan v. Director, Missouri Department of Health*[37], wherein the Court upheld patient autonomy by declaring that in order to oblige the physician to end life support, the State would require a "clear and convincing evidence" of the patient's desire to do so. Further, Misra C.J. and Bhushan C.J. have relied on the ruling in *Vacco v. Quill*[38], wherein the Court upheld a ban on physician assisted suicide by the State of New York and distinguished between physician assisted suicide and allowing a patient to refuse life support, opining that the latter was permissible as a part of the common law right of bodily integrity and individual autonomy. Similarly, Chandrachud J. and Bhushan J. have discussed the opinion of *Cardozo* J. in the ruling by New York Court of Appeals in *Schloendorff v. New York Hospital Trust*[39], in order to hold that individual autonomy protects the right of an individual to direct removal of life support in cases of terminal illness.[40]

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[35] *R (on the application of Pretty) v. Director of Public Prosecutions* [2001] UKHL 61.

[36] See *supra* note 9, at ¶626.

[37] *Cruzan v. Director, Missouri Department of Health* 497 U.S. 261 (1990).

[38] *Vacco v. Quill* 521 U.S. 793 (1997).

[39] *Schloendorff v. New York Hospital Trust* 211 N.Y. 125 (1914).

[40] See *supra* note 9 at ¶467.

Further, the bench has relied upon the jurisprudence in other jurisdictions such as Canada, Australia, Netherlands, Switzerland, Belgium and Singapore. For instance, Misra C.J. has cited the decision of the Supreme Court of Canada in *Carter v. Canada*[41], wherein physician assisted suicide was permitted in cases such as grievous and irremediable medical conditions, when such a wish was expressed in clear terms by an adult capable of consent. He has also discussed the safeguards of the Parliamentary Joint Committee appointed in 2016, for the purpose of providing substantive and procedural safeguards[42]. Hehas also borrowed from the same, and formulated safeguards for implementing advance directives in India. Additionally, he has reviewed the position in Australia, where advance directives and the right to refuse treatment have been considered as common law rights, and the best interest of the patient is the applicable standard to determine whether treatment can be withdrawn. For e.g. the High Court of Australia in *Secretary, Department of Health and Community Services (NT) v. JWB and SMB*[43], has held that common law protects the voluntary decisions of an adult person of sound mind as to what should be done to his/her body. In addition, he and Chandrachud J. have elucidated upon the rulings of the ECHR in *Pretty v. United Kingdom*[44], *Haas v. Switzerland*[45] and *Lambert v. France*[46].In these cases the Court observed that in 'end of life' situations the member States enjoy discretion, while striking a balance between the right to life and the autonomy of the patient, and permitting withdrawal of treatment. In such situations if sufficient safeguards are put in place, permitting passive euthanasia would not violate the obligations of the member States under the convention.

Further, the judges have mentioned the criteria set out by legislations in the Netherlands, Luxembourg and Belgium regarding the consent of the patient, i.e. the patient must have legal capacity, the medical state of the patient and his/her suffering, the presence of alternatives and the requirements of consulting other physicians etc.[47]These jurisdictions have prescribed these requirements very specifically and only allow euthanasia when any treatment is futile and the

[41] *Carter v. Canada*(2015) SCC 5.

[42] See, Hon. Kelvin K. Oglivie et al, *Medical Assistance in Dying: A Patient – Centered Approach: Report of the Special Joint Committee on Physician Assisted Dying,* PARL.CA ,https://www.parl.ca/Committees/en/PDAM.

[43] *Secretary, Department of Health and Community Services (NT) v. JWB and SMB*[1992] HCA 15.

[44] *Pretty v. United Kingdom*[2002] All E.R. (D) 286 (Apr.).

[45] *Haas v. Switzerland*[2011] ECHR 2422.

[46] *Lambert v. France*[2015] ECHR 545.

[47] See *supra* note 9 at ¶¶507 – 512.

suffering of the patient is unbearable and cannot be alleviated by other means. Furthermore, Bhushan J. has discussed the position in Switzerland wherein Articles 362 and 365 of the Swiss Civil Code, 1907 provide for execution and implementation of advance directives, and in Singapore, wherein the Advance Medical Directive Act, 1994 contains detailed provisions regarding the same.[48]

III. Procedure and Safeguards laid down by the Bench for the Issuance of Advance Directives and Attorney Authorisations–

In view of the abovementioned jurisprudence, Misra C.J. has rooted the right to die in dignity, as is found in Article 21. Considering it a matter of constitutional interpretation and therefore an obligation of the Court, he has laid down certain procedures and safeguards with respect to advance directives and attorney authorisations, that have been agreed upon and supplemented by other judges on the bench. The guidelines provide that only an adult of sound mind and ability to communicate, relate and comprehend the consequences of executing the document may voluntarily execute such a document after having full knowledge and information. The document must reflect informed consent clearly, and unambiguously instruct as to when medical treatment may be withdrawn or further treatment may not be given for prolongation of life. In addition, it should also contain a provision for revocation by the executor and must also disclose the name of a guardian who will give consent to refuse or withdraw treatment in accordance with the advance directive. The latest advance directive will be given effect in cases where there is more than one, however, the guidelines do not provide for situations where the directive is ambiguous. The presence of two attesting witnesses is required, who should preferably be independent, and the document must be countersigned by a Judicial Magistrate of First Class (hereinafter, JMFC) who is supposed to record satisfaction as to the voluntariness and informed consent of the executor. A copy of the document along with a digital one is to be preserved with the JMFC to prevent any future manipulation and another physical and digital copy is to be preserved with the Registry of the jurisdictional District Court. Further, a copy is to be preserved by the local authority as well i.e. municipality or panchayat as the case may be. If the family members are unaware, they are to be informed and where there is a family physician, he must be informed as well.[49]

[48] See *supra* note 9 at ¶ 625.

[49] See *supra* note 18.

The document can be given effect to at the instance of the doctor, only when the patient is terminally ill and after ascertaining the genuineness of the document from the JMFC. If the doctor has a conscientious or religious objection, then the hospital authorities are required to act. The doctor must inform the hospital authorities as to who will constitute a medical board consisting of the head of the treating department and three experts from various areas such as medicine, cardiology, nephrology etc. with experience in critical care and overall standing in the profession of atleast 20 years. The board shall then visit the patient in the presence of the nominated guardian and will certify whether or not the instructions in the document may be be carried out. If this preliminary opinion is in the affirmative, it will be communicated to the jurisdictional Collector, who will then constitute another medical board comprising of the Chief District Medical Officer as the chairman and three expert doctors from various fields such as cardiology, oncology, medicine etc. having a standing of atleast 20 years, except the doctors who were members of the previous board. If on visiting the patient, this board concurs with the opinion of the board constituted by the hospital, the decision will be communicated to the JMFC. The JMFC will then visit the patient at the earliest to authorise the implementation of the document. The executor is permitted to revoke the document at any stage prior to implementation by recording such revocation in writing. [50]

In cases where the medical board does not grant permission, it is open to the executor, or the relatives or even the doctor to file a writ petition under Article 226 before the High Court, and the Chief Justice of the said Court will be required to constitute a division bench to decide. It would be open to the High Court to constitute an independent medical board with the same qualifications as mentioned above and is also obliged to decide the matter expeditiously in the best interest of the patient. Further, there is no obligation to implement ambiguous directives.[51]Thus, the Court has provided comprehensive guidelines that will be applicable till the Parliament legislates on the subject.

In view of the experience in countries like the Netherlands[52] where advance directives have been permitted for a very long period of time, it is required to be seen that there is no lacuna in the implementation of these guidelines. In my opinion, the Court should have directed the

[50]*Id.*

[51]*Id.*

[52] See, Sofia Morrati et al, *Advance Directives in the Netherlands: The Gap Between Legal Regulation and Medical Practice,* in SELF DETERMINATION, DIGNITY AND END OF LIFE CARE: REGULATING ADVANCE DIRECTIVES IN INTERNATIONAL AND COMPARATIVE PERSPECTIVE, 287 – 298 (S. Negri ed., 2012).

constitution of an independent body consisting of judicial as well as medical experts to oversee the implementation of these guidelines in all cases. Afterall, considering the scarcity of resources and level of healthcare in India, there is definitely a risk of misuse of these directives and authorisations. Further, the directions do not provide any guidance as to when the "consent" of a person may be considered as an informed one. I believe the Hon'ble Court could have provided for mandatory psychiatric evaluation and counselling by medical practitioners before the person exercises his/her right to execute advance directives. Additionally, they do not prescribe a specific procedure for revocation of such directives and this may result in disputes as to whether or not the patient has revoked the advance directives. Ideally, a similar procedure could have been prescribed for the revocation of such directives. Furthermore, the Court has also opened an avenue for the misuse of this right by allowing the treating physician to approach the hospital authorities for constituting a medical board, in the absence of any directives or authorizations from a terminally ill patient with the informed consent of family members. Although the procedure specified by the Court would be followed in this case as well, taking such a step in the absence of such directives would be in contravention of the right to individual autonomy.

CONCLUSION

This judgment exemplifies the application of the doctrine of proportionality[53], wherein the Court has balanced two facets of the same right, i.e. the right to life under Article 21. While on one hand the right to life creates a compelling State interest in preserving human life, on the other hand it also assuresthe individual autonomy to take decisions with respect to his/her own body. The Court has carried out a measured analysis of the social, philosophical, ethical and economical aspects regarding this issue. Ithas carved out an exception to the principle of sanctity of life in cases where a person's life has lost any meaning and the prolongation of life is no longer in his best interest. Comparative jurisprudence has also been of much assistance to the Court while undertaking this exercise, an exhaustive examination of the international jurisprudence having been conducted by the members of the bench.

Taking cue from the judgment in *Visakha*[54], the Court has not only affirmed the right to die with dignity and to issue advance directives but has also provided detailed guidelines regarding the same.

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[53] "Proportionality is a legal principle that requires balancing between competing values." See, *Supra* note 7.

[54] *Visakha v. State of Rajasthan,* (1997) 6 SCC 241.