Review Article

Constitutional and Legal Protection for Life Support Limitation in India

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ABSTRACT

Appropriate treatment limitations towards the end of life to reduce unwanted burdens require ethical clarity that is supported by appropriate legislation. The lack of knowledge of enabling legal provisions, physicians feel vulnerable to legal misinterpretation of treatment limiting decisions. In India the lack of societal awareness, inadequate exploration of the gray areas of bio-ethics and unambiguous legal position relating to terminal illness have resulted in poor quality end of life care. Much of the perceived vulnerability by the physician is attributable to insufficient knowledge and understanding of existing constitutional and legal position in India. While we await informed legal and legislative opinion, this paper highlights possible legal liabilities arising from treatment limitation decisions with available defense. It is hoped that such clarity would lead to more confident ethical decisions and improved end of life care for patients.

Key words: End of life care in India, end of life care, euthanasia, foregoing life-support, intensive care, palliative care, passive euthanasia, treatment limitation

INTRODUCTION

The perceived lack of legal guidance is the greatest barrier to taking a treatment limiting decision in India.[1,2] This is in contrast to the increasing ease of such decisions elsewhere in the world.[3] Physician approach in India seems to be hampered by misperceptions of legal liability linked to treatment limitation, in major part due to the unclear signals from the legal community. Supreme court judgment has upheld suicide laws that may potentially be mis-applied to limitation decisions;[4] and the Law Commission of India had clarified many concepts but appear to have insufficient information regarding the needs of the dying patient and his/her family;[5,6] Aruna Shanbaug judgment pronounced ambiguously on passive euthanasia;[7] ethical code of the Medical Council of India (MCI) barely devotes a few lines on the question, focusing mainly on procedure for limitations at brain death and declaring euthanasia to be illegal.[8] In essence, the legal opinions appear to be ill-informed of the day-to-day ethical dilemmas surrounding foregoing of futile treatments toward the end of life.

Faced with the risks of lawsuits and societal unawareness of legitimate treatment foregoing options, the Indian Physician is often compelled to take the path of least resistance: to continue expensive, burdensome and heroic efforts till the very end, or resort to an ethically problematic "left against medical treatment" decision.[9-11] The result is that India has one of the poorest end-of-life care (EOLC) in the world with its individual

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and collective burdens.[12] In the face of this grim scenario, the well-meaning physicians continue to take appropriate decisions.[11,13] What are the legal and constitutional provisions for his/her defense?

EXISTING CONSTITUTIONAL PROVISIONS

The right to life and personal liberty is guaranteed by the Indian Constitution in Part III under the category of Right to Freedom (Articles 19–22). The right to life and personal liberty in accordance with the procedure established by law is guaranteed by Article 21 of the Indian Constitution.[14] In the Gopalan case, the court held that personal liberty relates to the person or the body of the individual.[15] The scope of personal liberty was made wider in 1973 and was held to remain despite executive and legislative directives.[16] From this flows the right to informed consent or refusal, which applies to all medical interventions. This alone would suffice for a foregoing of life sustaining treatments (FLST) decision.

In the case of P. Rathinam, the Supreme Court allowed the right to die when faced with intolerable suffering, thereby invalidating the suicide laws.[17] This opinion was superseded by the Gian Kaur judgment where the court ruled that the constitutional right to life enshrined in Article 21 cannot be interpreted as a right to take one's life.[4] It should be noted that the appeal was in relation to suicide and abetment to suicide (sections 306 and 309 IPC), not to terminally ill-patient sustained on artificial support. Significantly, in the latter case the judges made an exception in the situation of the dying patient allowing a "dignified process of death."

LEGAL PROTECTION AGAINST CRIMINAL LIABILITY

Section 300 IPC[18] for murder states as follows: "Except in the cases hereinafter excepted, culpable homicide is murder, if the act by which the death is caused is done with the intention of causing death, or if it is done with the intention of causing such bodily injury as the offender knows to be likely to cause the death of the person to whom the harm is caused."

Thus, according to Criminal Law either of two conditions must be met-intention and knowledge. The petitioner must prove motive on the part of the physician for act construed as murder. In a doctor-patient relationship, the motive is to offer cure or care unless established to be otherwise, the burden of proof resting with the appellant. The principle of prior knowledge is inapplicable as an FLST decision is considered only when treatment options are found to be ineffective to prevent death or intolerable disability. Therefore, the agency of death is attributable to the underlying disease condition rather than the withdrawal of artificial support. This is indeed a "failure to struggle" or a "letting die" rather than a positive act to end the life of the patient.[5,19] In as much as medical interventions are artificial and accepted by the patient through informed consent on the understanding that they would be beneficial, there is no imperative to continue, when the consent is withdrawn when no longer beneficial. Therefore, these actions on the part of the physician observing due medical processes are to be decriminalized. This is the clear position of a landmark judgment quoted in the Aruna Shanbaug case: In Airdale NHS Trust versus Bland (UK),[20] Lord Keith remarked "a medical practitioner is under no duty to continue to treat such a patient where a large body of informed and responsible medical opinion is to the effect that no benefit at all would be conferred by continuance of the treatment." This is also now the accepted position worldwide.[21-23]

The alternative to such interventions is not "no treatment" or abandonment. This misconception should be replaced by the positive concept of "comfort care" or palliative care.[23] The latter is a more holistic care as opposed to the burdensome approach of interventions. It shifts the focus to quality of life of the patient through addressing the physical, psychological, and spiritual needs. Continuing artificial feeding may actually give rise to unwanted symptoms or prolong the dying process without mitigating suffering.[24,25] Removal of artificial feeding and nutrition at the request of the husband of Terri Schiavo who had been in a chronic vegetative state was allowed by the US Supreme Court.[26] Of course, such decisions are complicated in the event of conflict within the family of the patient (Wendland case).[27] However, the issue of artificial medical interventions and their removal, subject to preconditions is widely accepted now extending also to implantable left ventricular assist devices.[28] Patient's rights override other considerations in interpreting section 300, 306, and 309 IPC. These decisions are meant to be taken forward on the condition of acceptability to all parties following open discussions of issues relevant to the patient's medical status.

Defenses available for criminal liability from the knowledge of possible harm during the life support withdrawal: These are available in the following sections when interpreted in the context of care of the dying patient.

Section 81, IPC

"Act likely to cause harm, but done without criminal intent, and to prevent other harm:"

By the doctrine of necessity and compulsion (*Jus necessitates*), if the physician is constrained to remove supports, even with the knowledge that the act may lead to death, it would not be a criminal act. The necessity and compulsion would be the patient's right to refuse consent to continue the futile intervention that would cause other more intolerable harm. Therefore, the existence of knowledge of consequences alone cannot render life support removal a criminal act. The circumstances of the act by this section would protect the physician.[29]

Section 88, IPC

"Act not intended to cause death, done by consent in good faith for person's benefit:"

The section, along with sections 89 and 92 of the code, deals with acts done for the benefit of others, whereas section 93 deals with communication made for the benefit of a person. Just as surgery or an intervention done in good faith to save a life but the results in death is not a criminal act, FLST decisions intended not to harm but to reduce suffering derive protection under this section.[29]

The Law Commission of India draft bills 176 and 241

These reports clearly separated euthanasia from FLST. Euthanasia is defined as the administration of a lethal drug by a physician as an act of mercy at the patient's request. FLST decisions differ fundamentally as it is only "letting die" - a decision not to intervene in a dying process already started. It pronounced FLST as lawful when a capable patient refuses treatment. Refusal to accept medical treatment does not amount to "attempt to commit suicide" and endorsement of FLST by the physician does not constitute "abetment of suicide." It also laid down that medical intervention contrary to patient's wishes amounts to battery and in some instances culpable homicide.

The draft bill 241, submitted in the wake of the Aruna Shanbaug judgment, endorsed the reforms suggested in the first report. It said "passive euthanasia" should be allowed on humanitarian grounds and for protecting doctors who genuinely act in the best interests of patients.[5,6]

Professional code of ethics

The MCI code of conduct has only one section pertaining to treatment limitation:

"Section 6.7: Euthanasia: Practicing euthanasia shall constitute unethical conduct. However, on specific occasion, the question of withdrawing supporting devices to sustain cardio-pulmonary function even after brain death, shall be decided only by a team of doctors and not merely by the treating physician alone. A team of doctors shall declare withdrawal of support system. Such team shall consist of the doctor in charge of the patient, Chief Medical Officer/Medical Officer in charge of the hospital and a doctor nominated by the in-charge of the hospital from the hospital staff or in accordance with the provisions of the Transplantation of Human Organ Act, 1994."[8]

Euthanasia has not been precisely defined although there are international consensus definition available. However, it does endorse, in specific circumstances, withdrawal of life support with the provision that it should be a collective and responsible decision. It does not propose any prerequisites and decision pathway unlike the Indian Society of Critical Care Medicine and the Indian Association of Palliative Care (ISCCM-IAPC) joint statement.[8,23]

Protection against suits under the Consumer Protection Act-1986

Professional negligence or medical negligence may be defined as want of reasonable degree of care or skill or willful negligence on the part of the medical practitioner in the treatment of a patient with whom a relationship of professional attendant is established, so as to lead to bodily injury or to loss of life.

In general, a professional man owes to its client a duty in tort, as well as in contract to exercise reasonable care in giving advice, or performing services. Duties which a doctor owes to his patient have been defined in this Act, which does not include duties toward the dying patient. A breach of any of these duties gives a right of action for negligence to the patient. It also states what is the benchmark of physician competence – "the practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. Neither the very highest nor a very low degree of care and competence judged in the light of the particular circumstances of each case is what the law requires."

The act goes on to state that physician is not guilty of negligence "if he acted in accordance with the practice accepted as proper by a reasonable body of medical men skilled in that particular art." As long as the doctor acts in a manner, which is acceptable to the medical profession and he treats the patient with due care and skill, the doctor will not be guilty of negligence even if the patient does not survive or suffers a permanent ailment.

For decisions regarding deficiency of service amounting to professional negligence, courts have relied on expert opinion, whether or not the physician has acted in conformity with standard practices in the profession. The ISCCM-IAPC joint statement along with the international consensus on FLST and EOLC would afford protection to bona fide physician decisions.[30]

CONCLUSIONS

Physicians while seeking legal and legislative clarity specific for treatment limitation and palliative care for dying patients continue to be unaware of these decisions. A closer look at existing constitutional and legal principles and reinterpreting them in the context of treatment futility would appear to sufficiently protect the bona fide end of life decisions.

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