xicology books, visit our website www.jaypeebrothers.com, for detailed information on forensic medicine & toxicology book

Forensic Medicine & Toxicology

VOLUME 3

Recent Advances in Forensic Medicine & Toxicology

Good Practice Guidelines and Current Medico-legal Issues

Editor
Gautam Biswas

Forewords
Stephen J Cina
VV Pillay

JAYPEE

Contents

SECTION 1: Medical Jurisprudence and Ethics

Chapter 1 **Humanitarian Forensics** 3
Uwom O Eze

Chapter 2 **Ethical Guidelines for Biomedical and Health Research Involving Human Participants** 15
Sandeep Kaushal

Chapter 3 **End-of-life Issues in India: A Legal Perspective** 35
Anil Kohli

Chapter 4 **Medico-legal Aspects of Trauma Management** 56
Magdy Kharoshah, Kholoud Samy Alsowayigh, Dalia Al Saif

SECTION 2: Forensic Pathology

Chapter 5 **Estimation of Range of Fire in Gunshot Wounds** 71
Lorenzo Gitto, Stephanie M Bryant, Michael PA Williams, Ponni Arunkumar, Serenella Serinelli

Chapter 6 **Choking Deaths Including Café Coronary: Autopsy Findings** 106
Murugesa Bharathi, Vinod Ashok Chaudhari

Chapter 7 **Lung Pathology in Deaths due to Opioid Toxicity with Special Emphasis on Asthma** 115
Serenella Serinelli, Ponni Arunkumar, Robert Stoppacher, Lorenzo Gitto

Chapter 8 **Autopsy Diagnosis of Deaths from Heat Stroke** 132
Swapnil S Agarwal

Chapter 9 **Mechanisms of Sudden Unexpected Death Secondary to Central Nervous System Neoplasms** 145
Timothy E Richardson, Serenella Serinelli, Kanish Mirchia, Kristyn Galbraith, Donald Jaeger, Michael PA Williams, Lorenzo Gitto

Chapter 10 **Time Since Death: Recent Developments** 163
Jagadeesh Narayanareddy

Chapter 11 **Emerging and Re-emerging Infectious Diseases: Role of Forensic Pathology Services in Detection and Biosafe Practices** 191
George Paul

Chapter 12 **Negative and Obscure Autopsy: Medico-legal Implications** 216
Prateek Rastogi

Chapter 13 **Artifacts and Mimics in Forensic Pathology** 223
Joseph A Prahlow

Chapter 14 **Human Body Preservation** 264
Ajay Kumar, Anu Sharma

Chapter 15 **Verbal Autopsy** 281
Ranabir Pal

SECTION 3: Forensic Radiology and Immunology

Chapter 16 **Postmortem Neuroimaging and Neuropathology** 295
Kavya Mirchia, Lorenzo Gitto, Sylvie Destian, Timothy E Richardson, Serenella Serinelli

Chapter 17 **Immunohistochemistry and its Forensic Importance** 312
Abhishek Das, Soumeek Chowdhuri

SECTION 4: Forensic Psychiatry

Chapter 18 **Unusual Sexual Practices and Sexual Crimes: An Overview** 335
Anil Aggrawal

Chapter 19 **Marriage, Divorce, Mental Illness, and the Law** 376
Uday Basu Roy Chowdhury, Roshni Basu Roy, Navkiran Mahajan

SECTION 5: Forensic Science

Chapter 20 **Forensic Pathologist in Crime Scene Investigation** 397
Amar Jyoti Patowary, Virendar Pal Singh

SECTION 6: Forensic Toxicology

Chapter 21 **Viscera Preservation: Current Guidelines and Recommendations** 423
Jatin Bodwal, Jitender Jakhar

Index 445

Chapter 3

End-of-life Issues in India: A Legal Perspective

Anil Kohli

"We cannot change the outcome, but we can affect the journey."
Ann Richardson (Hospice Volunteer and Author)

INTRODUCTION

End-of-life care (EoLC) has been exercising the minds of both doctors and the general public for some time. With the advancement in modern medicine it has become possible to prolong life which often leads to the question whether it is justified to prolong the suffering in a terminally ill patient or one who is in a vegetative state. It has also brought to the fore the question of euthanasia and advance directives. In India, there has been no legislation or policy with regards to this. As a result, the Courts were approached in this regard and the matter culminated in 2018 with the Supreme Court of India issuing guidelines in this regard. The guidelines are to remain valid till suitable legislation is brought out by the Parliament in this regard. This chapter examines the legal issues of EoLC in India, and especially the stand of the Indian Government, Law Commission and UN Human Rights Committee, and discusses the important and relevant judicial pronouncements of the Supreme Court on this issue. The detailed guidelines with regard to the legal issues (Advance Directives) given by the constitution bench of the Supreme Court of India in 2018 are discussed.

DEFINITIONS AND EXPLANATIONS

End-of-life Care

End-of-life care refers to healthcare for a person with a terminal condition that has become advanced, progressive, and/or incurable. EoLC includes physical, emotional, social, and spiritual support for patients and their families. The goal of EoLC is to control pain and other symptoms so the patient can be as comfortable as possible. EoLC may include palliative care, supportive care, and hospice care.

End-of-life care requires a range of decisions including questions of palliative care, patients' right to self-determination (of treatment, life), medical experimentation, the ethics and efficacy of extraordinary or hazardous medical interventions, and the ethics and efficacy even of continued routine medical interventions. In addition, EoLC often touches

JAYPEE BROTHERS

upon rationing and the allocation of resources in hospitals and national medical systems. Such decisions are informed both by technical and medical considerations, economic factors, as well as bioethics. In addition, end-of-life treatments are subject to considerations of patient autonomy.[1]

The World Health Organization definition of *palliative care* is set as "an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment, and treatment of pain and other problems, physical, psychosocial, and spiritual."[2]

End-of-life care varies enormously from country to country. The four core values of medical ethics involved are:

1. *Autonomy*: Patient has the right to choose or refuse the treatment.
2. *Beneficence*: A doctor should act in the best interest of the patient.
3. *Nonmalfeasance*: First, do no harm.
4. *Justice*: It concerns the distribution of health resources equitably.

Two more values of medical ethics are: (1) Dignity—the patient and the persons treating the patient have the right to dignity, (2) Truthfulness and honesty—the concept of informed consent and truth telling.[3] The Western model of palliative care which has evolved around these values of medical ethics may be at times be difficult to adhere to looking at the current framework of palliative care available in India.[4]

The Indian Society of Critical Care Medicine had developed directives to deal with such issues in India. The document essentially dealt with physician's attitude toward the severely ill patients in ICU. It also referred to physician's objective and subjective assessment, honest and accurate disclosure of prognosis, early option of palliative care in poor prognosis, and ensuring consistency among the caregiver team. It also gave a checklist as when to put the patient on EoLC (i.e., withdrawal of life supports within the bounds of law). The directives are not laws and only guidelines for proper behavior of the intensivist/physician for severely ill patients.[5]

Research involving patients in EoLC often leads to a lot of ethical challenges. Inclusion of patients for palliative care research involves unique situations:[6]

- Dying patients are especially vulnerable.
- Adequate informed consent may be difficult to obtain.
- Balancing research and clinical roles is particularly difficult.
- Risks and benefits of palliative care research are difficult to assess.

There is no policy in India at a national level on palliative care and EoLC.

Euthanasia

Euthanasia is an intentional premature termination of another person's life either by direct intervention (active euthanasia) or by withholding life-prolonging measures and resources (passive euthanasia). The Oxford English Dictionary defines "euthanasia" as "the painless killing of a patient suffering from an incurable and painful disease or in an irreversible coma".

It can either be at the express or implied request of that person (voluntary euthanasia), or in the absence of such approval/consent or when the consent is unavailable when the patient is in coma or is otherwise unable to give consent (nonvoluntary euthanasia). *Active euthanasia*, also known as positive euthanasia or aggressive euthanasia, entails a positive act or affirmative action or act of commission entailing the use of lethal substances or forces to

JAYPEE BROTHERS

cause the intentional death of a person by direct intervention, e.g., a lethal injection given to a person with terminal cancer who is in great agony. *Passive euthanasia*, on the other hand, also called negative euthanasia or nonaggressive euthanasia, entails withdrawing of life support measures or withholding of medical treatment for continuance of life, e.g., removal of the heart-lung machine from a patient in coma. The legal position across the world seems to be that while active euthanasia is illegal unless there is a legislation permitting it; passive euthanasia is legal even without legislation, provided certain conditions and safeguards are maintained. In passive euthanasia, the doctors are not actively killing the patient; they are merely not saving him and only accelerating the conclusion of the process of natural death which has already commenced.

Active euthanasia is illegal in most parts of the world. The jurisdictions in which it is permissible are Belgium, Canada, Netherlands, Colombia, Luxembourg, and Western Australia. Physician-assisted suicide is permissible in Switzerland, Germany, Australian states of Victoria and the States of Colorado, Vermont, Montana, Maine, California, Oregon, New Jersey, District of Columbia, Hawaii, and Washington DC in the United States (US).[7]

There is a distinction between euthanasia and *physician assisted deaths/suicide*. The difference lies in the fact as to who administers the lethal medication. In active euthanasia, a physician or third party administers it, while in physician-assisted suicide, it is the patient who does it though on the advice of the doctor.

Advance Medical Directives

Advance medical directives pertain to treatment preferences and the designation of a surrogate decision-maker in the event that a person should become unable to make medical decisions on his or her own behalf. The Black's Law Dictionary defines an "advance medical directive" as a legal document explaining one's wishes about medical treatment if one becomes incompetent or unable to communicate.

Advance directives generally fall into three categories: (1) Living will, (2) Power of attorney, and (3) Healthcare proxy.[8]

1. A *"living will"* is a written order which a person passes when he is alive to refuse medical treatment when he goes into coma or a persistent vegetative state (PVS). The orders can be: "Do Not Resuscitate (DNR), Do Not Intubate (DNI) and Allow Natural Death (AND)". DNR order relates to circumstances where a patient has a cardiorespiratory arrest and no vigorous cardiopulmonary resuscitation (CPR), i.e., chest compressions, cardiac drugs, or placement of a breathing tube is given. This DNR order is a well-documented and accepted concept in most of the developed countries and is practiced in most parts of the world without much legal issues. DNI order means that chest compressions and cardiac drugs may be given, but no breathing tube will be placed. Another concept is "*allow natural death*". This term is used in some hospitals as an alternative to the more traditional DNR order. "*Allow natural death*" order is used to make sure that only comfort measures to provide excellent control of pain or other symptoms are taken. This includes withholding or discontinuing resuscitation, artificial feedings, fluids, and other treatments that prolong the dying process without adding to patient's quality of life. Allowing a natural death means not interfering with the natural dying process. It also means that every effort will be made to ensure the patient's time of death to be calm and peaceful.[9-11]
2. Another type of advance medical directive is *"medical power of attorney"*. It is a document which allows an individual (principal) to appoint a trusted person (agent)

JAYPEE BROTHERS

to take healthcare decisions when the principal is not able to take such decisions. The agent appointed to deal with such issues can interpret the principal's decisions based on his/her mutual knowledge and understanding. The durable power of attorney allows an individual to make bank transactions, sign "social security cheques", apply for disability, or simply write cheques to pay the utility bills, while an individual is medically incapacitated.[8]

3. *"Healthcare proxy"* is a legal document in which an individual designates another person to make healthcare decisions, if he or she is rendered incapable of making his or her wishes known. The healthcare proxy has, in essence, the same rights to request or refuse treatment that the individual would have, if capable of making and communicating decisions.

Advance directives have been lawfully recognized in several jurisdictions by way of legislation, and in certain countries through judicial declarations. In most of the states in the US, it is mandatory for the doctors to give effect to the wishes of the patients as declared by them in their advance directives. California was the first State to legally sanction living will. In Florida (US), an unconscious patient was brought by paramedics with the phrase "Do Not Resuscitate" tattooed on his chest. The doctors were in a dilemma as to whether to provide any medical treatment to the patient. The doctors opted not to provide any medical procedure, and the patient died later on.

Persistent Vegetative State

A persistent vegetative state (PVS) or post-coma unresponsiveness (PCU) is a disorder of consciousness in which patients with severe brain damage are in a state of partial arousal rather than true awareness. There is complete absence of behavioral evidence for self or environmental awareness. There is preserved capacity for spontaneous or stimulus-induced arousal, evidenced by sleep-wake cycles. They have normal heart beat and breathing, and do not require advanced life support to preserve life. They cannot produce a purposeful, coordinated, voluntary response in a sustained manner, although they may have primitive reflexive responses to light, sound, touch or pain. After four weeks in a vegetative state (VS), the patient is classified as in a persistent vegetative state.

POLICIES ON EUTHANASIA

International positions on various aspects of euthanasia differ between countries, European Court of Human Rights, UN Human Rights Committee, etc.

The stand taken by the Law Commission of India, the Indian Government and policy of United Nations with regard to "euthanasia" is explained briefly below in order to understand why the matter had to in the interim be settled by the Supreme Court of India.

Law Commission of India

In 2006, the Law Commission of India in its 196th report "on medical treatment to terminally ill patients (protection of patients and medical practitioners)" discussed the issue of euthanasia in detail and also gave a draft bill—"The Medical Treatment of Terminally Ill Patients (Protection of Patients and Medical Practitioners) Bill, 2006". The report made it clear at the outset that "euthanasia" and "assisted suicide" continue to be unlawful and the commission was dealing a different matter, that is, "with-holding life support measures" to patients "terminally ill". Universally in all countries, such

JAYPEE BROTHERS

withdrawal is treated as "lawful". A 100 years ago, when medicine and medical technology had not invented the artificial methods of keeping a terminally ill patient alive by medical treatment including by means of ventilators and artificial feeding, such patients were meeting their death on account of natural causes. Today, it is accepted, a terminally ill person has a common law right to refuse modern medical procedures and allow nature to take its own course, as was done in good old times. It is well-settled law in all countries that a terminally ill patient who is conscious and is competent, can take an "informed decision" to die a natural death and direct that he or she should not be given any medical treatment, which may merely prolong life. There are currently a large number of such patients who have reached a stage in their illness when according to well-informed body of medical opinion, there are no chances of recovery. But modern medicine and technology may yet enable such patients to prolong life to no purpose, and during such prolongation, patients could go through extreme pain and suffering. Several such patients prefer palliative care for reducing pain and suffering and do not want medical treatment which will merely prolong life or postpone death. One important aspect of the Bill was that it held every advanced directive executed by a person to be void and not binding on the medical practitioner.[12]

In 2011, the Law Commission was asked to give its opinion on the feasibility of bringing out a law on euthanasia taking into account the earlier 196th report of the Law Commission and the judgment of the Supreme Court in the Aruna Ramchandra Shanbaug case where the court laid down the law on passive euthanasia regarding incompetent patients, such as those in PVSs or those in coma or those of unsound mind. In August 2012, Law Commission came out with a detailed 241st report titled "Passive Euthanasia—A Relook" on the issue of passive euthanasia, wherein it approved the concept of "Right to Self Determination". The Law Commission was in agreement with the views expressed by the previous Law Commission and the Supreme Court that passive euthanasia be allowed, subject to certain safeguards. It felt that on humanitarian considerations, and to protect the doctors who genuinely act on the best interests of terminally ill patients, a law was necessary. The main difference between the draft bill of the 196th report and the Supreme Court guidelines was that whereas the Law Commission felt that there should be an enabling provision for the doctor to approach the High Court for declaratory relief, the Supreme Court made it mandatory to get clearance from the High Court to give effect to the decision to avoid life support. There was also a difference in the preparation and constitution of the panel of medical experts. Accordingly, changes were made in the earlier draft Bill titled "The Medical Treatment of Terminally Ill Patients (Protection of Patients and Medical Practitioners) Bill". The Law Commission of India clarified that where a competent patient takes an "informed decision" to allow nature to have its course, the patient is, under common law, neither guilty of attempt to commit suicide (u/s 309 IPC) nor is the doctor who omits to give treatment, guilty of abetting suicide (u/s 306 IPC) or of culpable homicide (u/s 299 read with Section 304 of IPC).[13]

Indian Government

The Ministry of Health and Family Welfare, Government of India, was initially not in favor of enactment of any law with regard to any form of euthanasia (affidavit filed before the Supreme Court in 2016) due to the following reasons:

- "Hippocratic oath" is against intentional/voluntary killings of patient.
- Progression of medical science to relieve pain, suffering, rehabilitation, and treatment of so-called diseases will suffer a setback.

JAYPEE BROTHERS

- An individual may wish to die at certain point of time, his/her wish may not be persistent and only a fleeting desire out of transient depression.
- Suffering is a state of mind and a perception, which varies from individual to individual and depends on various environmental and social factors.
- Continuous advancement in medical science has made possible good pain management in patients of cancer and other terminal illness. Similarly, rehabilitation helps many spinal injury patients in leading near normal life, and euthanasia may not be required.
- Wish of euthanasia by a mentally ill patient or in depression may be treatable by good psychiatric care.
- It will be difficult to quantify suffering, which may always be subject to changing social pressures and norms.
- Can doctors claim to have knowledge and experience to say that the disease is incurable and patient is permanently invalid?
- Defining of bedridden and requiring regular assistance patients is again not always medically possible.
- There might be psychological pressure and trauma to the medical officers who would be required to conduct euthanasia.

Thereafter, various meetings were held by experts, and the expert committee set up had proposed formulation of legislation on passive euthanasia. The Bill sent by the Law Commission was referred to the technical wing of the Ministry of Health and Family Welfare (Directorate General of Health Services) for examination.

The government also decided to solicit public opinion/comments before formulation of a law on passive euthanasia. It had uploaded a draft bill on a government website titled—"Terminally Ill Patients (Protection of Patients and Medical Practitioners) Bill, 2016", on 6th May 2016, along with the explanatory brief mentioned in the Law Commission's 241st Report.[14] The matter remained under consideration and the Supreme Court constitution bench meanwhile gave its judgment on the issue in 2018 by framing guidelines for "advanced directives" (which it legalized) in passive euthanasia as an interim measure till the matter gets legislated.

United Nations

The United Nations International Covenant on Civil and Political Rights (ICCPR) attempts to ensure the protection of civil and political rights. It was adopted by the United Nations' General Assembly on December 19, 1966, and it came into force on March 23, 1976. Right to life under Article 6(1) of the ICCPR states that "every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life." The second sentence of Article 6(1) imposes a positive obligation on the States to provide legal protection of the right to life. However, the subsequent reference to life not being arbitrarily deprived operates to limit the scope of the right (and therefore, the States duty to ensure the right). Comments from the United Nations Human Rights Committee suggest that laws allowing for voluntary euthanasia are not necessarily incompatible with the States obligation to protect the right to life.[15]

The United Nations Human Rights Committee has emphasized that laws allowing for euthanasia must provide effective procedural safeguards against abuse, if they are to be compatible with the States obligation to protect the right to life. It has to be stated without any trace of doubt that the right to life with dignity has to include the smoothening of the process of dying when the person is in a vegetative state or is living exclusively by the

JAYPEE BROTHERS

administration of artificial aid that prolongs the life by arresting the dignified and inevitable process of dying.

INDIAN LEGAL PERSPECTIVE

P Rathinam v. Union of India

Two individuals, namely, P Rathinam and Nagbhushan Patnaik, filed two Writ Petitions under Article 32 of the Constitution which were decided by a two-Judge Supreme Court Bench in P Rathinam v. Union of India and another in 1994.[16] The writ petitions assailed the constitutional validity of Section 309 of the Indian Penal Code (IPC) contending that the same is violative of Articles 14 and 21 of the Constitution. The judgment held that Section 309 of the IPC deserves to be effaced from the statute book to humanize our penal laws. It is a cruel and irrational provision, and it may result in punishing a person again (doubly) who has suffered agony and would be undergoing ignominy because of his failure to commit suicide. Also an act of suicide cannot be said to be against religion, morality or public policy, and an act of attempted suicide has no baneful effect on society. Further, suicide or attempt to commit it causes no harm to others, because of which State's interference with the personal liberty of the persons concerned is not called for. Answering all the questions, the Court declared Section 309 IPC ultra vires and held that it deserved to be effaced from the statute book to humanize our penal laws.

Gian Kaur v. State of Punjab

In Gian Kaur v. State of Punjab,[17] the Supreme Court Constitution Bench in 1996 considered the correctness of the decision rendered in P Rathinam. This case questioned the constitutionality of Section 306 of the IPC.

In the said case, the appellants were convicted by the trial Court under Section 306 IPC and the conviction was assailed on the ground that Section 306 IPC is unconstitutional and to sustain the said argument, reliance was placed on the authority in P Rathinam wherein Section 309 IPC was held to be unconstitutional being violative of Article 21 of the Constitution. It was urged that once Section 309 IPC had been held to be unconstitutional, any person abetting the commission of suicide by another is merely assisting in the enforcement of the fundamental right under Article 21 and, therefore, Section 306 IPC penalizing abetment of suicide is equally violative of Article 21.

The two-Judge Bench before which these arguments were advanced in appeal referred the matter to a Constitution Bench for deciding the same. In the course of arguments, one of the amicus curiae had submitted that the debate on euthanasia is not relevant for deciding the question of constitutional validity of Section 309, and Article 21 cannot be construed to include within it the so-called right to die, since Article 21 guarantees protection of life and liberty and not its extinction. Thereafter, the Constitution Bench in Gian Kaur scrutinized the reasons given in P Rathinam and opined that the Court in the said case took the view that if a person has a right to live, he also has a right not to live. The Court in Gian Kaur observed that the Court in P Rathinam, while taking such a view, relied on the decisions which relate to other fundamental rights dealing with different situations and those decisions merely hold that the right to do an act also includes the right not to do an act in that manner. The larger Bench further observed that in all those decisions, it was the negative aspect of the right that was involved for

JAYPEE BROTHERS

which no positive or overt act was to be done. The Constitution Bench categorically stated that this difference has to be borne in mind while making the comparison for the application of this principle.

The Constitution Bench ruled that "right to life is a natural right embodied in Article 21, but suicide is an unnatural termination or extinction of life, and therefore, incompatible and inconsistent with the concept of right to life. With respect and in all humility, we find no similarity in the nature of the other rights, such as the right to freedom of speech, etc., to provide a comparable basis to hold that the right to life also includes the right to die. With respect, the comparison is inapposite for the reason indicated in the context of Article 21. The decisions relating to other fundamental rights wherein the absence of compulsion to exercise a right was held to be included within the exercise of that right are not available to support the view taken in P Rathinam qua Article 21. It has been clarified that the right to die with dignity at the end of life is not to be confused or equated with the right to die an unnatural death curtailing the natural span of life."

Thereafter, the Court proceeded to state that "a question may arise in the context of a dying man who is terminally ill or in a PVS that he may be permitted to terminate it by a premature extinction of his life in those circumstances. This category of cases may fall within the ambit of the right to die with dignity as a part of right to live with dignity, when death due to termination of natural life is certain and imminent, and the process of natural death has commenced. These are not cases of extinguishing life, but only of accelerating conclusion of the process of natural death, which has already commenced. The debate even in such cases to permit physician-assisted termination of life is inconclusive. It is sufficient to reiterate that the argument to support the view of permitting termination of life in such cases to reduce the period of suffering during the process of certain natural death is not available to interpret Article 21 to include therein the right to curtail the natural span of life."

In view of the aforesaid analysis and taking into consideration various other aspects, the Constitution Bench declared Section 309 IPC as constitutional.* The Court held that the "right to live with human dignity" cannot be construed to include within its ambit the right to terminate natural life, at least before the commencement of the process of certain natural death. It accepted the submission that Section 306 is constitutional. Thus, the Court in Gian Kaur, apart from overruling P Rathinam, upheld the constitutional validity of Section 306 IPC.

Although the controversy relating to attempt to suicide or abetment of suicide was put to rest, yet the issue of euthanasia remained alive. It came to the fore in another case filed before the Supreme Court in 2011, Aruna Ramchandra Shanbaug v. Union of India.

Aruna Ramchandra Shanbaug v. Union of India

The controversy regarding euthanasia arose again for consideration almost after a span of 15 years in 2011 in Supreme Court of India in Aruna Ramchandra Shanbaug v. Union of India.[18] In Aruna Ramchandra Shanbaug, after referring to the authority in Vikram Deo Singh Tomar v. State of Bihar, the Court reproduced paragraphs 24 and 25 from Gian Kaur's case and opined that the said paragraphs simply mean that the view taken in P Rathinam's case to the effect that the right to life includes the right to die is not correct and para 25 specifically mentions that the debate even in such cases to permit physician-assisted

* It may be noted that attempt to commit suicide (Section 309 IPC) has been decriminalized as per the Mental Healthcare Act, 2017.

JAYPEE BROTHERS

termination of life is inconclusive. The Court further observed that it was held in Gian Kaur that there is no right to die under Article 21 of the Constitution, and the right to life includes the right to live with human dignity but in the case of a dying person who is terminally ill or in permanent vegetative state, he may be allowed a premature extinction of his life and it would not amount to a crime.

The court addressed the legal issues, namely, active and passive euthanasia. The court also copiously referred to the decision in *Airedale case*. The Airedale NHS Trust v. Bland case in the House of Lords in 1992. Anthony Bland was injured in the Hillsborough Field soccer crisis when he was 17 years old, and had been in a PVS ever since, with no signs of ever leaving that state. He could breathe by himself, but required a feeding tube and numerous antibiotics, as well as full care to ensure that he remained in relative good health. His parents decided that he would not want this, and had asked the doctors to remove the feeding tube to put an end to his life. The lower courts allowed the removal of the tube which his guardian appealed. The case was finally heard in the House of Lords which dismissed the appeal. Lord Goff observed that discontinuance of artificial feeding in such cases is not equivalent to cutting a mountaineer's rope or severing the air pipe of a deep sea diver. The real question has to be not whether the doctor should take a course in which he will actively kill his patient but whether he should continue to provide his patient with medical treatment or care which, if continued, will prolong his life. Lord Browne Wilkinson was of the view that removing the nasogastric tube in the case of Bland cannot be regarded as a positive act causing death. The tube by itself, without the food being supplied through it, does nothing. Its removal does not cause death, since the tube by itself does not sustain life. The learned Judge observed that removal of the tube would not constitute the *actus reus* of murder, since such an act by itself would not cause death. Lord Mustill observed that it was in the best interests of the community at large that Anthony Bland's life should now end. The doctors have done all they can. Nothing will be gained by going on, and much will be lost. The distress of the family will get steadily worse. The strain on the devotion of a medical staff charged with the care of patient whose condition will never improve, who may live for years and who does not even recognize that he is being cared for will continue to mount. The larger resources of skill, labor, and money now being devoted to Anthony Bland might, in the opinion of many, be more fruitfully employed in improving the condition of other patients, who if treated may have useful, healthy, and enjoyable lives for years to come.[19]

The two-Judge Supreme Court Bench further observed that the decision in Airedale by the House of Lords has been followed in a number of cases in the UK, and the law is now fairly well settled that in the case of incompetent patients, if the doctors act on the basis of notified medical opinion and withdraw the artificial life support systems in the patients best interest, the said act cannot be regarded as a crime.

The learned Judges posed the question as to who is to decide what the patient's best interest is when he is in a PVS. The Court answered that it is ultimately for the Court to decide, as *parens patriae* (the monarch, or any other authority, regarded as the legal protector of citizens unable to protect themselves), as to what is in the best interest of the patient. However, the wishes of close relatives, next friend, and the opinion of medical practitioners should be given due weight when coming to a decision. For the said purpose, reference was made to the opinion of Balcombe J whereby it has been stated that the Court as representative of the Sovereign and as *parens patriae* will adopt the same standard which a reasonable and responsible parent would do. In the ultimate analysis, the Court opined that the Airedale case is more apposite to be followed.

JAYPEE BROTHERS

Thereafter, the Court adverted to the law in India and ruled that in Gian Kaur case, that Court had approved the decision of the House of Lords in Airedale and observed that euthanasia could be made lawful only by legislation. After so stating, the learned Judges opined:

"It may be noted that in Gian Kaur case, although the Supreme Court has quoted with approval the view of the House of Lords in Airedale case, it has not clarified who can decide whether life support should be discontinued in the case of an incompetent person, e.g., a person in coma or PVS. This vexed question has been arising often in India because there are a large number of cases where persons go into coma (due to an accident or some other reason) and are unable to give consent, and then the question arises as to who should give consent for withdrawal of life support. This is an extremely important question in India because of the unfortunate low level of ethical standards to which our society has descended, its rampant widespread commercialization, and the rampant corruption, and hence, the Court has to be very cautious of the possibility that unscrupulous persons with the help of some unscrupulous doctors may fabricate material to show that it is a terminal case with no chance of recovery. In our opinion, if we leave it solely to the patients' relatives or to the doctors or next friend to decide whether to withdraw the life support of an incompetent person, there is always a risk in our country that this may be misused by some unscrupulous persons who wish to inherit or otherwise grab the property of the patient.

In our opinion, while giving great weight to the wishes of the parents, spouse, or other close relatives or next friend of the incompetent patient and also giving due weight to the opinion of the attending doctors, we cannot leave it entirely to their discretion whether to discontinue the life support or not. We agree with the decision of Lord Keith in Airedale case that the approval of the High Court should be taken in this connection. This is in the interest of the protection of the patient, protection of the doctors, relatives and next friend, and for reassurance of the patient's family, as well as the public. This is also in consonance with the doctrine of *parens patriae,* which is a well-known principle of law."

It was further opined that the High Court can grant approval for withdrawing life support of an incompetent person under Article 226 of the Constitution because Article 226 gives abundant power to the High Court to pass suitable orders on the application filed by the near relatives or next friend or the doctors/hospital staff praying for permission to withdraw the life support of an incompetent person.

Dealing with the procedure to be adopted by the High Court when such application is filed, the Court ruled that when such an application is filed, the Chief Justice of the High Court should forthwith constitute a Bench of at least two Judges who should decide to grant approval or not, and before doing so, the Bench should seek the opinion of a Committee of three reputed doctors to be nominated by the Bench after consulting such medical authorities/medical practitioners as it may deem fit. Among the three doctors, as directed, one should be a neurologist, one should be a psychiatrist, and the third a physician. The Court further directed that the committee of three doctors nominated by the Bench should carefully examine the patient and also consult the record of the patient, as well as take the views of the hospital staff and submit its report to the High Court Bench.

Simultaneously, with appointing the committee of doctors, the High Court Bench shall also issue notice to the State and close relatives, e.g., parents, spouse, brothers/sisters, etc., of the patient, and in their absence his/her next friend, and supply a copy of the report of the doctors committee to them, as soon as it is available. After hearing them, the High Court Bench should give its verdict. The High Court should give its decision speedily at the earliest, since delay in the matter may result in causing great mental agony to the relatives

JAYPEE BROTHERS

and persons close to the patient. The High Court should give its decision assigning specific reasons in accordance with the principle of best interest of the patient laid down by the House of Lords in Airedale case. The views of the near relatives and committee of doctors should be given due weight by the High Court before pronouncing a final verdict which shall not be summary in nature.

The above procedure should be followed all over India, until Parliament makes legislation on this subject.

Common Cause (A Registered Society) v. Union of India

A Writ Petition was preferred in the Supreme Court in 2005 under Article 32 of the Constitution of India by the petitioner, a registered society, seeking to declare right to die with dignity as a fundamental right within the fold of right to live with dignity guaranteed under Article 21 of the Constitution. The society also prayed to issue directions to the respondents to adopt suitable procedure in consultation with the State Governments, where necessary, to ensure that persons of deteriorated health or terminally ill patients should be able to execute a document titled "My Living Will" and "Attorney Authorization" which can be presented to the hospital for appropriate action in the event of the executant being admitted to the hospital with serious illness, which may threaten termination of the life of the executant; to appoint a committee of experts including doctors, social scientists, and lawyers to study into the aspect of issuing guidelines as to the "Living Wills"; and to issue such further appropriate directions and guidelines as may be necessary.[20]

The Aruna Ramchandra Shanbaug v. Union of India matter was decided when the present Writ Petition was pending for consideration. The present petition was, thereafter, listed before a three-Judge Bench which noted the submissions advanced on behalf of the petitioner and also that of the learned Additional Solicitor General on behalf of the Union of India.

In Aruna Ramchandra Shanbaug v. Union of India it was interpreted that the decision of the Constitution Bench in Gian Kaur was that euthanasia can be allowed in India only through a valid legislation. However, it was also factually wrong to interpret that in Gian Kaur case, the Constitution Bench approved the decision of the House of Lords in Airedale NHS Trust v. Bland.

From the aforesaid, the three-Judge Bench expressed the view that the opinion of the House of Lords in Airedale had not been approved in Gian Kaur and to that extent, the observation in Aruna Ramchandra Shanbaug was incorrect. After so stating, the three-Judge Bench opined that Aruna Ramchandra Shanbaug upholds the authority of passive euthanasia and lays down an elaborate procedure for executing the same on the wrong premise that the Constitution Bench in Gian Kaur had upheld the same. Thereafter, considering the important question of law involved which needs to be reflected in the light of social, legal, medical, and constitutional perspectives in order to have a clear enunciation of law, it referred the matter for consideration by the Constitution Bench of this Court for the benefit of humanity as a whole. The three-Judge bench further observed that it was refraining from framing any specific questions for consideration by the Constitution Bench as it would like the Constitution Bench to go into all the aspects of the matter and lay down exhaustive guidelines.

That is how the matter came before the Constitution Bench. The Constitution Bench thought it necessary to first clear the maze whether the Constitution Bench in Gian Kaur had accepted what has been held in Airedale.

JAYPEE BROTHERS

The Constitution Bench on a careful and anxious reading of Gian Kaur noticed that there had been narration, reference, and notice of the view taken in Airedale case. It was also worth noting that the Court was concerned with the constitutional validity of Section 309 IPC that deals with attempt to commit suicide and Section 306 IPC that provides for abetment to commit suicide. As noted earlier, the Constitution Bench, while distinguishing the case of a dying man who is terminally ill or in a PVS and his termination or premature extinction of life, observed that the said category of cases may fall within the ambit of right to die with dignity as a part of right to life with dignity, when death due to termination of natural life is inevitable and imminent, and the process of natural death has commenced. The Constitution Bench further opined that the said cases do not amount to extinguishing the life, but only amount to accelerating the process of natural death which has already commenced, and thereafter, the Constitution Bench stated that the debate with regard to physician assisted suicide remains inconclusive. The larger Bench had reiterated that the cases pertaining to premature extinction of life during the process of certain natural death of patients who are terminally ill or in PVS were of assistance to interpret Article 21 of the Constitution to include therein the right to curtail the natural span of life.

On a seemly understanding of the judgment in Gian Kaur, the Constitution Bench did not find that it had decried euthanasia as a concept. On the contrary, it gave an indication that in such situations, it is the acceleration of the process of dying which may constitute a part of right to life with dignity so that the period of suffering is reduced. Be it clarified, it is understood and appreciated that there is a distinction between a positive or overt act to put an end to life by the person living his life and termination of life so that an individual does not remain in a vegetative state or, for that matter, when the death is certain because of terminal illness and he remains alive with the artificially assisted medical system. It has been clarified that the right to die with dignity at the end of life is not to be confused or equated with the—right to die an unnatural death curtailing the natural span of life.

In Gian Kaur, while dealing with the attempt to commit suicide, the Court clearly held that when a man commits suicide, he has to undertake certain positive overt acts and the genesis of those acts cannot be tested to or be included within the protection of the expression right to life under Article 21 of the Constitution. It was also observed that a dignified procedure of death may include the right of a dying man to die with dignity when the life is ebbing out. This is how the pronouncement in Gian Kaur has to be understood. Therefore, it can be held without any hesitation that Gian Kaur has neither given any definite opinion with regard to euthanasia nor has stated that the same can be conceived of only by legislation. The Bench felt that that passive euthanasia comes within the sweep of Article 21 of the Constitution, and had no iota of doubt that the Bench could lay down the Guidelines for it. The Bench also made it clear that as part of the right to die with dignity in case of a dying man who is terminally ill or in a PVS, only passive euthanasia would come within the ambit of Article 21, and not the one which would fall within the description of active euthanasia in which positive steps are taken either by the treating physician or some other person.

The Court on enquiring into common law and statutory rights of terminally ill persons in other jurisdictions found indications that all adults with the capacity to consent have the common law right to refuse medical treatment and have the right of self-determination.

A competent person who has come of age has the right to refuse specific treatment or all treatment or opt for an alternative treatment, even if such decision entails a risk of death. The "Emergency Principle" or the "Principle of Necessity" has to be given effect to only

JAYPEE BROTHERS

for detailed information on forensic medicine & toxicology books, visit our website www.jaypeebrothers.com, for detailed i

Recent Advances in Forensic Medicine & Toxicology

The *Recent Advances in Forensic Medicine and Toxicology* is an ideal resource for keeping abreast of new developments and concepts in this constantly changing field of forensic medicine and toxicology. The latest volume in this series is written by experts in their field of specialty; featuring current topics in forensic pathology, as well as major subspecialties. This edition includes chapters on humanitarian forensics, advance directives, ethical issues in human experimentation, immunohistochemistry, safe practices for handling BSL-3/BSL-4 infected bodies, forensic neuroradiology, gunshot injuries, artifacts, viscera preservation, medical negligence, heat stroke deaths, negative and obscure autopsy, verbal autopsy, forensic pathologist in crime scene investigation, etc. This book provides excellent revision material for postgraduate examinations, and keeps faculty up-to-date.

The book is sub divided into six sections:

- Section I focuses on "Medical Jurisprudence and Ethical Issues".
- Section II deals with "Forensic Pathology".
- Section III covers "Forensic Radiology and Immunology".
- Section IV discusses "Forensic Psychiatry".
- Section V deals with "Forensic Science".
- Section VI covers "Forensic Toxicology".

- All the topics are well illustrated with color photographs, diagrams, text boxes, tables, and flowcharts for clear communication of concepts, and focuses on significant recent developments in the field.
- Specialized topics, which are not so frequently encountered, including both legal obligations and ethical responsibilities of those involved in forensic setting are also discussed.
- Each chapter is extensively researched and referenced.

Gautam Biswas did his MBBS and MD (Forensic Medicine) from University College of Medical Sciences and GTB Hospital, Delhi. He began his career in 2001 as a Lecturer in Forensic Medicine and Toxicology at Dayanand Medical College and Hospital, Ludhiana, Punjab. He is currently serving in the same institute as a Professor and Head of the Department. In 2010, his book for the undergraduates "Review of Forensic Medicine and Toxicology" was published by M/s Jaypee Brothers Medical Publishers (P) Ltd. New Delhi, and is running successfully into its fifth edition and has been written as per the latest competency based medical education (CBME) guidelines of National Medical Commission (NMC). In 2016, the "*Practical and Postmortem Record Book of Forensic Medicine and Toxicology*" was published, and was widely accepted by students and faculty since it filled the vacuum of a standardized record book. This book has been revamped into *Manual Practical Forensic Medicine and Toxicology* as per the CBME guidelines. He is the editor of this immensely popular book *"Recent Advances in Forensic Medicine and Toxicology"* which is a reference book for the postgraduates and faculty of all disciplines, and published every 3 years. He is also the editorial board of the journal "Torture" and National Advisory Board of "Journal of Forensic Medicine and Law".

Printed in India

Available at all medical bookstores or buy online at www.jaypeebrothers.com



JAYPEE BROTHERS
Medical Publishers (P) Ltd.
EMCA House, 23/23-B, Ansari Road,
Daryaganj, New Delhi - 110 002, INDIA
www.jaypeebrothers.com

Join us on facebook.com/JaypeeMedicalPublishers

Shelving Recommendation
FORENSIC MEDICINE & TOXICOLOGY

