ISCCM Position

The constitutional and legal provisions in Indian law for limiting life support

S. Balakrishnan, R. K. Mani[1]

Introduction

The absence of guidelines for withdrawal and withholding of life support in Indian law is perceived to be the most important obstacle to the practice of appropriate end of life care. In addition, physicians appear to be apprehensive about their civil or criminal liability when called upon to make decisions to limit life-supporting therapies. The following account explores the existing Constitutional and legal provisions that can reasonably be used by physicians in their defense. The article provides illustrative case histories that bring to focus the ethical dilemmas commonly faced by the physician. It also spells out the need for new legislation specifically addressing EOL issues.

Constitutional provisions

Right to refuse treatment

Resolving the dispute between the rival claims of a society's (or care-giver's) right to impose a particular medical treatment on an individual and the right of the individual to refuse the treatment would ultimately depend upon the answer to the question – in what direction does the larger interests of the society lie?

Generally, the claims of the society prevail when public health concerns are involved, e.g., there can be compulsory vaccination to prevent out-break of an epidemic. However, the claims of the individual should prevail where the treatment in question affects the individual and his family members alone. In such cases, the individual has an undoubted right to refuse treatment.

From:
Senior lawyer, Supreme Court of India, [1]Consultant Pulmonologist and Intensivist

This right springs from the duty of the society to respect, preserve, and not trample upon the freedom of the individual to have his own opinion and decisions in matters that essentially concern only himself. Individual liberty is the hallmark of any free society.

Article 21 of the Constitution of India enshrines an important fundamental right.[1] It reads:

'Protection of life and personal liberty: No person shall be deprived of his life or personal liberty except according to procedure established by law.'

Though the Article appears to be negative in grammatical form, it has been in reality given a positive content by judicial interpretation. Under the canopy of Article 21 of the Constitution, many rights have found shelter, growth and nourishment. The rights to die with dignity and to refuse treatment have to be seen in this article of the Constitution of India. It is also well settled that any provision of law which comes in conflict with or which is in derogation of the Fundamental Rights guaranteed under the Constitution of India will be invalid.

Thus, if we keep the concept of 'treatment' as distinct and different from 'public health,' then, to the question whether any patient has a right to refuse treatment, the answer is a resounding affirmative.

On projecting the enquiry further, we are faced with a few questions that are more intricate:

1. Does the right to refuse treatment extend to refusal of life supporting systems?

2. Does it extend to the extent that the individual can insist on the removal of life supporting systems?
3. Does the exercise of these rights, at any point cease to be the exercise to lawful (if not fundamental) rights and enter the forbidden zone of suicide?
4. If an individual, to begin with, has these rights, then, does he lose them when he becomes incompetent for decision-making as in a state of unconsciousness?
5. In cases of unconscious patients or patients who cannot interact or communicate their decisions who is entitled to exercise these rights for and on behalf of these patients?

Indian Law has no clearly stated position on any of these issues. The opinion of professional bodies must therefore precede the evolution of legal provisions in matters concerning life-supporting interventions, as no relevant case laws exist in the country.

There is an urgent need for fresh legislations on these issues. We need to work towards developing the following laws in order to facilitate end of life care:

1. Right to Refuse (informed refusal of) Treatment Act.
2. Withdrawal and withholding of Life-Sustaining Treatment Act.
3. Right to Palliative Care Act.

Suicide and abetment to suicide

Section 309 of the Indian Penal Code (IPC) deals with attempt to commit suicide and section 306 IPC deals with abetting to suicide.[2]

On the question as to whether an attempt to commit suicide should be punishable or not (validity of Section 309 of IPC) different judges of the Supreme Court of India have expressed divergent views.[3] A bench of two judges of the Supreme Court in the case of P. Rathinam *vs* Union of India 1994[3] SCC 394 held section 309 of IPC as violative of the individual's Fundamental Rights guaranteed under the Constitution of India. This view, however, was short- lived. In Gian Kaur *vs* State of Punjab 1996[2] SCC 648, a larger Bench of Supreme Court over-ruled the aforesaid earlier decision.

This judgment contains an observation in paragraph 24 that sheds light on the distinction between suicide on the one hand and the exercise of a right resulting in what the Supreme Court has termed as a 'dignified procedure of death,' on the other. This important observation of the Supreme Court reads as follows: 'The right to life including the right to live with human dignity would mean the existence of such a right up to the end of natural life. This also includes the right to a dignified life up to the point of death including a dignified procedure of death. In other words, this may include the right of a dying man to also die with dignity when his life is ebbing out. But 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.' It is clear that the honorable judges only disallowed an intentional act curtailing life and they did not pronounce the act of stopping futile treatments as unlawful. Thus according to the Supreme Court, the 'right to life' (a Fundamental Right guaranteed under Article 21 of the Constitution of India) includes the 'right of a dying man to also die with dignity when his life is ebbing out.'

The above observation is the earliest obscure attempt to distinguish between the 'right' and the 'wrong' in cases of withholding and withdrawal of life support. The judgment cannot be used to interpret all acts of withdrawal and withholding of life support as 'suicide' and therefore illegal.

The refusal of any modality of treatment including life support is not an act of suicide or an attempt at suicide. Acknowledgement of this Right of refusal on the part of the physician cannot be interpreted as Euthanasia. Black's Law Dictionary[4] defines Euthanasia as 'the act or practice of painlessly putting to death persons suffering from incurable and distressing disease as an act of mercy.' This is entirely different from withholding or withdrawing life support in obvious cases of terminal illness and of known futility.

Legal provisions

There are certain defenses available to the doctors under some of the existing sections of the IPC Sections 76, 81, and 88 are relevant in this connection.[2] There is ample scope in these sections to protect the actions of well meaning doctors. The applicability of these sections of the Indian Penal Code deserve to be explored in the context of charges arising from end of life cases.

Section 76: Act done by a person bound, or by mistake of fact believing himself bound by law:

'Nothing is an offence which is done by a person who is, or who by reason of mistake of fact and not by reason of mistake of law in good faith believes himself to be, bound by law to do it.'

Section 81: Act likely to cause harm, but done without criminal intent, and to prevent other harm:

'Nothing is an offence merely by reason of its being done with the knowledge that it is likely to cause harm, if it be done without any criminal intention to cause harm, and in good faith for the purpose preventing or avoiding other harm to person or property.'

Explanation

'It is a question of fact in such a case whether the harm to be prevented or avoided was of such a nature and so imminent as to justify or excuse the risk of dong the act with the knowledge that it was likely to cause harm.'

Section 88: Act not intended to cause death, done by consent in good faith for persons benefit:

'Nothing, which is not intended to cause death, is an offence by reason of any harm which it may cause, or be intended by the doer to cause, or be known by the doer to be likely to cause, to any person for whose benefit it is done in good faith, and who has given a consent whether express or implied, to suffer that harm, or to take the risk of that harm.'

Comments

Section 76 can be invoked in certain circumstances:

A physician caring for a critical illness, may believe that there are compelling medical reasons for a particular decision, say, withholding of treatment. He may be proven wrong by hindsight or by facts that emerged later. He may not be guilty of any offence if,

a) he has clearly documented the medical reasons for withholding the treatment;
b) The mistake he might be shown to have made is one of fact that emerged later but not according to widely accepted medical opinion.

Section 81 may be invoked in relation to decisions of withholding or withdrawing treatment because all of these are done with the knowledge that these decisions cause harm in the physiological sense. These decisions are taken deliberately to spare the patient and his family the greater harm of futile prolongation of the dying process, adding burdensome, expensive, and often painful treatments and possible financial ruin. Documented medical reasons should indicate, that the harm to be avoided outweighs the risk of harm from withholding/withdrawal decisions.

Section 88 is also relevant for withdrawal and withholding decisions, as they do not directly intend to cause death. Their purpose is only not to retard the natural process of dying, which appears inevitable. In these cases, death is primarily caused by the underlying disease and not by withholding or withdrawal of futile medical interventions.

This section is also relevant to the application of palliative care wherein the physician administers potent analgesics or sedatives that may, as a side effect, depress respiration and expedite death. This, so called 'double effect' in American Law is permissible, if the intention is not to cause death, but to alleviate pain, distress or breathlessness.

The essential ingredients of such a case would be that:

1) The patient must qualify for palliative care (by diagnosis, medical decision, and patient's consent).
2) The drugs administered should be in doses that are in keeping with standard recommendations.
3) The drug, dosage, and timing of administration and the side effect are clearly documented in the case records. This would testify to the honorable intentions of the physician.

Areas of legal vulnerability while taking end of life decisions

While legislative reforms are awaited, the question is, under the present legal climate what is the legal vulnerability of the doctor despite taking a bonafide decision with the full consensus of the family and duly documenting the procedure. Subsequently, the family may move court against the physician in one of following ways:

1) A suit may be filed in a Civil Court claiming damages alleging negligence or in a Consumer Court under alleging 'deficiency in service.'[5]
2) A Criminal case may be lodged by registering a re-

port with the Police or by filing a complaint in a Court.

If a Civil Suit is filed the complainant has to deposit *advaleram* (proportionate) Court Fee but a proceeding under the Consumer Protection Act in the Consumer Forum can be initiated for claims of any amount without depositing a court fee. Therefore, the current trend is to move the consumer court. Here we must see the meaning of 'deficiency,' which is defined under section 2(1) (g) of the Consumer Protection Act and 'service,' which is defined under section 2(1) (o). In the case of civil suit, the existence of 'negligence' would become the core issue.

The Consumer Act defines deficiency to mean 'any fault, imperfection, shortcoming or inadequacy in the quality nature and manner of performance which is required to be maintained by or under any law for the time being in force or has been undertaken to be performed by a person in pursuance of a contract or otherwise in relation to any service.'

When it comes to judging as to whether there has been any negligence or deficiency in service, then Courts have repeatedly laid down that the test to be adopted is whether the doctor has acted in conformity with the standards prevailing in his profession.

It is here that the guidelines framed by the Indian Society of Critical Care Medicine (ISCCM) assume importance because they express the consensus of the members of the profession defining the ethical and medical standards and laying down the procedure to be followed in making end of life decisions. The touchstone for the Court to judge the conduct of the doctor in Civil cases, claiming damages on the basis of allegations of negligence or deficiency in service, would be the accepted and proclaimed norms of the profession concerned. It provides a defense in all bonafide cases against claims for damages in Civil Suits and in Consumer disputes. In the case of L.B. Joshi *vs* T.B. Godbole the Supreme Court has held that 'the law requires that the practitioner must bring to his task a reasonable degree of skill and knowledge and he must exercise a reasonable degree of care, neither the very highest nor the very low degree of care and his competence is judged in the light of the particular circumstances of each case.' The test of the reasonableness of the decision of the doctor would essentially depend upon the norms set out and announced by the professional body.

For moving criminal proceedings, the burden to prove the charge will be heavily on the complainant. The complainant has to be present (unless exempted) during every hearing before the Court. Taking an over all perspective, the chances are that the offended family member may opt for a damages claim rather than for a criminal proceeding. In the latter situation, the Sections 76, 81, and 88 of the IPC can certainly be availed of by the doctors in defense of their position.

Illustrative examples of cases that raise ethical and legal issues

Case 1

A 50-year-old patient was admitted in a state of coma. Investigations conducted previously showed findings on CT scan clearly suggestive of a highly malignant tumor of the brain. The patient's family had taken many opinions but no definitive investigation to confirm the suspicion of cancer had been conducted. Presently the family demanded that a needle biopsy of the brain be performed no matter what the risks may be. The husband, who is a doctor himself, demanded treatments that are unsuitable for a patient with advanced cancer. At his insistence a bronchoscopic examination was performed which revealed a mass further testifying to the advanced stage of the cancer. A needle biopsy of the brain lesion confirmed a highly malignant tumor, which carried a virtually hopeless prognosis. In the opinion of several experts, treatment was futile. Postoperatively patient's neurological state became worse rendering her brain dead. The family continued to demand that all treatments should continue including antibiotics, ventilation and vasopressors to maintain blood pressure. Attempts at counseling by the treating physician only led to the family opting to change their physician. Futile treatments continued to be provided on the plea that the family has the right to demand treatment.

Comment: This case clearly demonstrates the unreasonable position that a family can take sometimes. Awareness of the futility of continuing curative treatment in certain situations is still low in the society and sometimes it is so even among doctors. Often the patient can find obliging doctors who experience no crisis of con-

science in applying futile treatments. Inappropriate treatment continues to be tolerated and even endorsed while appropriately holding back treatment is misrepresented as 'euthanasia' or 'abetment to suicide.' All this is because the legal position with respect to 'appropriateness' of life-sustaining therapies is unclear in Indian law. When provisions for withholding and withdrawal are available and observance of 'good practice norms' as established elsewhere in the world and by professional bodies in India are encouraged, such outrageous violation of the patient's body and misuse of scarce resources will be reduced.

When bronchoscopy revealed advanced stage of cancer, what then was the need for performing the risky needle biopsy of brain lesion thereafter? Anyway, when needle biopsy rendered the patient brain-dead, why should one treat with antibiotics, ventilation, and vasopressors? In such cases, what is the respect being given to the patient's body?

Legal perspective: In such cases, the existing state of law leaves no scope for independent decision by the physician except to persuade the patient's relatives to see reason.

Case 2

A 68-year-old lady was admitted with a severe infection of the lungs (severe sepsis) and rapidly developed kidney failure. She went on to develop multiple organ failure and deep coma over the next 2 weeks. Over the subsequent two weeks, she was sustained on daily dialysis, mechanical ventilation, artificial nutrition and large doses of several vasopressors. The family by this time felt drained emotionally and financially. While the doctors daily gave a virtually hopeless prognosis, all the life-sustaining therapies were being continued in full measure, much to the consternation of the family. When the family questioned the usefulness of these measures, the doctors took the view that withholding any of these life-sustaining therapies would be tantamount to euthanasia, which is illegal. The family asserted that the patient had, before becoming unconscious, clearly expressed her desire not to have a death that is artificially prolonged. They also referred to the case of another relative living abroad, who in similar circumstances had his ventilator removed by doctors at the request of his family, as he himself had lost his cognitive powers. They wondered why this couldn't be done in the present case. Despite these requests the doctors took the view that withdrawal of these therapies would be possible only if the family was willing to take the patient away 'against medical advice' (LAMA). The family was apprehensive of taking such a step. At the request of the family, a second opinion was sought. After discussions, it was clear that both the caregiver team and the family believed that the patient was terminally ill. The hospital policy was against withdrawal of ventilator support. Therefore, a decision was taken to scale down the vasopressors to the lower end of the recommended dose and all treatments aimed at cure (being obviously futile) such as antibiotics were stopped. The discussions and the decisions were clearly documented in the case records. Orders were written not to escalate any treatment or add new treatment. Dialysis support was also stopped. The family members expressed a sense of relief that their loved one will not be 'tortured.' Free access to the patient was allowed. Social workers were asked to provide emotional support. The patient passed away peacefully after one day and the family expressed their gratitude to the hospital.

Comment: The case illustrates the commonly held position of the doctors – that of self-defense. Doctors tend to believe that their obligation is confined to instituting treatments aimed at cure even in hopeless situations and that it does not include 'good' management of the dying patient. They also seem to be oblivious of the wishes and sentiments of the family. All this gives the impression to the family that the patient is not being treated as a person and interventions are ordered mechanically. Doctors also seem to confuse holding back of inappropriate therapies with euthanasia. The insistence on 'LAMA' when the patient is dying seems utterly callous and is against the spirit of caring that is central to physician–patient relationship. Awareness of the ethical obligations and existence of laws that clearly define withdrawal and withholding of therapies in defined circumstances would improve the quality of care given to the dying patients and their family members. Subsequent decisions taken on the lines of the ISCCM's 'EOL' recommendations provided relief to the distressed family. This case also illustrates how introduction of these simple ethical rules can reduce suffering. Misuse potential of EOL decisions is negligible compared to the enormous burdens imposed by indiscriminate application of life-support technologies.

Legal perspective: It is the lack of clear legislative provisions, which makes the doctors and hospital administrators confuse the holding back of inappropriate therapies with euthanasia. This leads them to insist on 'LAMA' instead of taking the responsibility on themselves. Ethical standards demand that appropriate medical decision be taken even if an enactment of law is awaited.

Case 3

A 40-year-old man underwent complicated heart surgery and subsequently developed severe sepsis. After 3 weeks of aggressive therapy, the patient was terminally ill with his blood pressure sustained by high-dose vasopressor therapy, and an intra-aortic balloon pump (IABP). Respiration was being maintained by mechanical ventilation. The family had accepted at the patient had little or no chance of survival. The family was facing a financial crisis. When family requested discounts, doctors advised that they could take the patient away as 'LAMA.' This confused and alarmed the family. Caught between the prospect of financial ruin if they continued to stay on in the hospital the one hand and taking a step that would lead to the death of their loved one, on the other, they experienced anguish and helplessness. A second opinion was sought. De-escalation of treatment was proposed respecting the family's wishes. Redundant and futile treatment was withdrawn, considerably reducing costs. IABP was withdrawn, as it could not change the inevitable outcome. All decisions were clearly recorded in the case records to ensure transparency. The patient passed away peacefully a few hours later, much to the relief of the family. There was no further conflict with the treating team.

Comment: De-escalation of treatment cannot be interpreted as euthanasia or abetment to suicide as doctors are not obliged to continue treatment that in their judgment are not appropriate. Clarity of the legal position in this matter would enable doctors to apply or withhold treatment wisely without risking frivolous litigation.

Legal perspective: Here it may be noted that if faced with a lawsuit the physician could invoke sections 82 and 88 of IPC in their defense. The physician may be aware of the consequences of 'de-escalation' but he does not desire to bring about the death of the patient. Therein lies the difference between knowledge and intention. Inasmuch as the doctors do not intend to cause death they can plead section 88 of IPC in defense.

Case 4

A 75-year-old retired bureaucrat was transferred from another hospital where five attempts at weaning him off mechanical ventilation had failed. He had undergone treatment for metastatic prostate cancer with no benefit. He was fully conscious and aware of his physical condition and the poor long-term outlook for his disease. Several attempts at liberating him from the ventilator over a period of a month failed. The patient himself did not wish to continue being sustained on ventilatory support and his family supported his decisions. The patient's doctor requested some more time to enable him to wean the patient off the ventilator, as he was trying several different ways to accomplish this. Despite the patient's pleas not extend his life artificially his physician continued to postpone the discontinuation of life supports. The doctor felt that he was trapped between the ethical obligation of respecting his patient's wishes and legal concern that current Indian law would equate withdrawal of ventilatory support to the abetment of suicide. After 6 weeks of failed weaning attempts, the doctor had no option but to respect the patient's wishes. The physician gave the patient either the option of signing the 'LAMA' form and thus refuse all treatment or allowing the doctor to make one last attempt at discontinuing the ventilator and not reintroducing it if the attempt failed. The doctor appeared more comfortable about not reinitiating support and felt that the passive act of withholding support would be viewed differently from withdrawal. The patient was assured compassionate care with adequate measures to provide relief from distress and pain. The patient and family chose the second option, and the patient's end came soon and peacefully.

Comment: Indian law does not touch upon vital areas of medical treatment towards end of life. It does not state clearly whether a patient has the right to refuse a treatment that is considered futile by professional opinion, or even if it may be potentially beneficial. Suicide laws confuse the issue because the latter concerns only a deliberate act to destroy oneself, in the absence of any disease. The interpretation of Articles 21 and 14 needs to be restated to give a new meaning to the right to privacy in the context of terminal illness and medical interventions. The doctor's moral obligations that are universally acknowledged must be taken into account and not a

narrow interpretation of sections 306 and 309 of the IPC. It should also be made clear that there is ethically no difference between withholding and withdrawal of life support as both serve to stop futile interventions. The right to receive palliative treatment is essential to the implementation of forgoing life support, as it is the physician's foremost duty to alleviate pain and distress.

Legal perspective: If embroiled in litigation, the physician in this case can invoke section 88 of IPC, because while he had the knowledge of the consequences of his acts of omission or commission, he did not intend the same. The physician in extending compassionate care at the patient's end of life has no desire to bring about his death. Intention is knowledge coupled with desire for the result. The desire on the part of the physician is only to protect the patient from agony and to respect his right to refuse treatment.

All the four cases discussed above (being real life events) show the *urgent* need for well thought out legislation covering the end of life issues, providing for respect for the body of the patient, his personal values and ensuring death with dignity.

References

1. The Constitution of India: Articles 21 & 14.
2. Indian Penal Code: Sections 309; 306; 76; 81; 88.
3. Supreme Court Judgments in: P.Rathinum vs. Union of India 1994 (3) SCC 394.
4. Gian Kaur vs. State of Punjab 1996 (2) SCC 648.
5. Dr. LB Joshi vs. TB Godbole AIR 1969 SC 128; 1969 (1) SCR 206.
6. *In*: Black HC. editor. Black's The Consumer Law Dictionary. 6th edn. West Publishing Co: 1991. p. 554.
7. Protection Act 1986: Section 2 (1) (g) & 2 (1) (o)