The jurisprudence of emergency medical care in India: an ethics perspective

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Abstract

This paper, which is part of a primary interdisciplinary doctoral research work with a qualitative research design, seeks to understand the ethical principles that intersect healthcare jurisprudence in litigations where citizens, who have encountered death or violations in the provision of critical care, have had to take recourse to the courts to get justice.

Primary data was triangulated from (i) a review of 10 judgments of the Supreme Court of India and high courts on emergency medical care and medical negligence, selected through a keyword search in legal databases, and (ii) 45 in-depth and expert interviews conducted with judges, advocates, public health experts and petitioners. The respondents were selected on the basis of purposive sampling and snowballing methods. The analysis was guided by the political-economic and moral-ethical perspectives of the right to healthcare.

"Preservation of/saving life" and "duty of care" are established as absolute, non-negotiable and supreme constitutional obligations of the medical profession and the State. Conversely, refusing adequate and emergency care in institutions such as police stations, prisons, railways, and public and private medical establishments is considered a violation of the fundamental right to life. Even though ethics jurisprudence is constrained by the commercial-profiteering ethos, especially in the context of Indian healthcare policy, the analysis points to the fact that principles of right to life and dignity do lay the foundation of discourse on healthcare jurisprudence in India. This provides a strong basis for enhancing care for citizens and shaping the healthcare system to meet critical, chronic and emergency needs.

Introduction

The goals of medicine, as laid down in the Hippocratic Oath, are founded on profound moral-ethical principles, which require healthcare providers to be committed to the mitigation of suffering, to uphold the primacy of life and to recognise their corresponding obligations (1). However, historically, the medical profession has grown beyond the individual doctor–patient or researcher–subject relationship, characterised by mere care giving, into a complex organisation that exercises power and authority, influences political decisions concerning healthcare, and functions even as a business enterprise (2). Codified bioethics principles evolved in close relation to medical research under varied historical circumstances, and have had a greater influence on research ethics than on the practice of medical care (3). Consequently, the process of translating the noble goals of medicine and integrating ethical principles into public health ethics as operating principles of the healthcare system has been slow and fraught with struggle (4,5).

Globally, in the face of violations of the human right to health and the breach of ethical principles in health and medical care, citizens have resorted to the judicial-legal system, which has resulted in a process referred to as "judicialisation of healthcare" (6). Judicial-legal principles emerging from court judgments are referred to as public healthcare or social rights jurisprudence and quite often have ethical-moral overtones. Legal scholars have alluded to the influence of such jurisprudence on healthcare policies in several countries (7). In India, violations of patients' rights have escalated into a widespread systemic phenomenon on account of the low political priority given to public health in policy and planning. The major systemic challenges in healthcare are inadequate financial, (8,9) human and infrastructural resources (10), the lack of regulatory measures to oversee the private healthcare sector, and the lack of measures aimed at protecting patients' rights (11–13). Citizens and civil society organisations have fought against violations of the right to life and dignity in healthcare by filing social action litigations in the Supreme Court of India (SCI) and high courts (HCs), and have also approached quasi-judicial/legal bodies, such as the National Consumer Dispute Redressal Commission (NCDRC). Historically, litigations related to the denial of life-saving care, including emergency medical care, in the 1980s set a precedent for healthcare litigations. This paved the way for a rudimentary judicial discourse on ethical principles in the apex court of the country (14).

The issue of emergency medical care, which often includes dealing with life and death situations, brings into sharp focus several intersecting concerns regarding health services, the rights of patients, and the duty of the State and medical profession. The indignity caused by the refusal to treat patients in critical condition, resulting in the loss of life, undue suffering, consequent morbidity and financial loss have been challenged in courts on the ground of moral-ethical principles that form the core of the medical profession and the raison d'être of the healthcare system in a welfare State. This research paper aims to (i) examine the types of healthcare issues raised in litigations related to emergency medical care, and (ii) analyse and synthesise the jurisprudence on public healthcare ethics

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that has evolved through these judicial-legal processes, along with the implications of this jurisprudence for public health and healthcare policy in India. The term "ethics jurisprudence" used in this paper refers to an analysis and synthesis of the discussions on ethics that underlie the judicial-legal principles in court judgments on litigations related to emergency care.

Methodology

This paper is part of a primary interdisciplinary doctoral research work which had a qualitative research design and used the document analysis and in-depth interview methods. The formerentailed a four-stage process of finding, selecting, appraising and synthesising judgments from the SCI, HCs and other judicial domains. Data were gathered by searching legal databases through keywords, reviewing the literature on legal and human rights, and case-referencing (15). This resulted in the selection of 401 judgments and orders, after the inclusion and exclusion criteria had been applied. For the purpose of analysis, the insights and perspectives culled from the 45 in-depth and expert interviews conducted for the doctoral research were triangulated with the data from the review of the documents of judgments. The methods of purposive sampling and snowballing were used for the selection of the respondents. This resulted in cohorts of three judges, four advocates, 20 public health/health rights experts and 18 petitioners/litigants. The cohorts of public health rights experts and petitioners overlap due to their expertise, but are treated as mutually exclusive categories in this research. They included experts and researchers from the domains of women's rights, medical ethics and public health rights. All respondents, barring three, were from India. Of the in-depth interviews with the key informants, 30 were formal, semi-structured interviews and 15 were structured e-mail interviews. Methods of thematic and content analysis were used to synthesise the salient features of jurisprudence in relation to the social right to healthcare.

The thematic analysis of the various orders was carried out using the process of "case congregation", which resulted in the identification of several thematic domains and sub-domains (16). Within each domain and sub-domain, the orders were organised using the lens of power and the court's position in the hierarchy of the judicial system. The judgments/orders were put in chronological order on the basis of their dates, and this provided a historical perspective. Next, content analysis of each thematic domain and sub-domain was carried out.

Of the universe of 401 judgments, data from 10 of the judgments selected and organised under the thematic domain of emergency medical care have been considered for this paper.The essential jurisprudential principles associated with ethics, sifted out on the basis of the content analysis, have been triangulated with the insights gained from the interviews on the issues of the right to healthcare, in general, and ethics and emergency care, in particular. The analysis is guided by the political-economic and moral-ethical perspectives of the right to healthcare.

Atlas-ti software was used for organising the data.The study was carried out from January 2014 to December 2015.

The research process included a two-step institutional process in Jawaharlal Nehru University, Delhi. The research proposal and protocol were first examined and approved by the Committee for Advanced Scientific Research of the School of Social Sciences. Subsequently, the Institutional Ethics Review Board (IERB) followed its own process, which included a personal interview with the researcher, and the presentation of the ethics protocols and research tools. The proposal has been approved by the IERB. All but three of the litigant-respondents were from urban settings, educationally qualified and English-speaking, and had a sufficient knowledge of their rights and ethical protocols in research. The purpose of the research and ethics protocols was explained to all the respondents and their written informed consent was obtained. In the case of rural respondents, the consent form was translated into their languages (Hindi and Kannada) and the research protocols, including their rights as participants in the research, were explained to them in detail in their own languages.

Case profiles

Of the 10 litigations analysed, eight refer to mishaps of various kinds (accidents, cardiac arrest and custodial ill treatment), while two refer to generic policy issues (medical negligence and protection of bystanders). The litigations are analysed under the following five themes.

Accidents, delay in or denial of care – public healthcare institutions

The three cases considered illustrate two types of emergencies – accidents: a motor vehicle accident (17), a fall from a train (18), and a medical emergency, such as a cardiac problem (19). In all three, the patient was refused admission on the ground that there were no beds available. In one case (18), the victim (Hakim Sheikh) was an agricultural labourer who was a member of the *Paschim Banga Khet Mazdoor Samiti*, a labour union. He fell from a moving train on his way to work, and was denied admission in five public hospitals. In the first case, the victim died and in the other two, the victims were finally admitted to private hospitals and had to pay exorbitant amounts for their treatment.

Private hospitals and medical professionals

The earliest litigation on record on medical negligence in post-Independence India was filed by one doctor against another. It was initially filed in an ordinary court in Maharashtra. The trial court, HC and SCI, upheld the charge of medical negligence in a legal process that lasted 14 years (20). The deceased, the son of the respondent-doctor, had met with an accident in which he had fractured his left femur. He was taken to the hospital of the appellant and operated upon. However, he was not given an adequate dose of anaesthesia and died after the surgery. In another case, the complainant was a medical doctor who lost his 20-year-old son. The deceased was a student of an engineering college in Kolkata. Even though the boy was medically insured, the hospital staff discontinued his treatment because the family did not deposit Rs 15,000 instantly. He died while being taken to another hospital (21).

Public enterprises and accidents

The issue considered in a writ petition (22) related to the provision of emergency medical care for "all" involved in railway accidents. The railways used to cater only to authorised passengers. The issues of free medical treatment and saving life were not considered in the case of accidents involving either people crossing the railway tracks or unauthorised (ticketless) passengers. This led to several deaths.

Public authorities, custody and emergency medical care

Two cases, which fall under medico-legal and criminal litigation, illustrate the widespread but under-reported issue of ill treatment, torture and lack of medical care in police custody. An accused, who was thrashed by a mob for an alleged robbery on a train, was tied to a cycle rickshaw by the police and taken to the police station. However, he was not given any medical treatment and consequently died (23). Another person met with an accident while driving and a criminal case was brought against him for drunken driving. As he was not provided timely medical care, he died in police custody (24).

Medical care and policies

The case of *Indian Medical Association vs V.P. Shantha* (25) exemplifies the long-standing resistance of the medical profession to any regulation of medical professionals on the pretext of professional self-regulation. In this case, the definition of service as applicable to healthcare under different conditions was contested to determine the status of the healthcare-seeking patient as a consumer.

Collectively, the litigations point to the denial of admission in public hospitals, invariably resulting in death or subsequent treatment in private hospitals. They also point to medical malpractices and ethical violations in private hospitals. These include the discontinuation of medical care for not depositing money instantly, negligence in medical care and charging exorbitant amounts for treatment. The complete failure to provide medical care for people in police custody is another aspect that is brought out by the cases.

The interviews provided profound insights into the political-economic perspective of healthcare, negligence in medical care and how this is reflected in the deterioration of ethics in the medical profession, as well as in the provision of healthcare in India. Though very few respondents elaborated clearly on the issue of emergency healthcare, most of them viewed the denial of healthcare services during emergencies as symptomatic of the overall malaise of unethical practices, corruption, commercialisation and unaccountability that has set in within the medical profession. In the respondents' opinion, the prime reasons why unethical practice is flourishing are the political and policy eco-system, which promotes unscrupulous and unregulated private healthcare, and the health policy, which ignores the healthcare needs of the masses. The legal community members interviewed – both judges and lawyers – were all human rights-oriented and were critical of the judicial-legal processes. Nonetheless, they expressed confidence in the role and power of the courts, which they believed could curb these violations. The petitioners' accounts vividly brought out the travails of fighting court battles for the cause of healthcare, and the vulnerability they felt in the courts due to the uncertainty, delays, changes in benches, and their extreme dependence on the availability of sensitive and *pro bono* lawyers with human rights perspectives. The duration of the litigations in which they were involved ranged from 5 years to 28 years, and some of them had given up midway. In such circumstances, even a small number of litigations – 10 in the case of emergency healthcare – highlight their significance in jurisprudence.

Emergency care, ethics and jurisprudence

The Constitution of India, to a large extent, embodies the moral-ethical principles of human rights and social rights jurisprudence of the international human rights law. In the late 1970s, ie the post-Emergency era, and the 1980s, the SCI broke out of the traditional legal framework to venture to interpret the Constitution from a liberal standpoint, which gave rise to the phenomenon of public interest litigations (PILs). A series of PILs filed after that helped develop the jurisprudence of personhood, upholding the primacy of the right to life and dignity. Article 21 of the Constitution was thus established as the cornerstone of social rights and civil-political rights, including health and healthcare. Emergency care forms one of the segments of the vast number of healthcare litigations, the others being the workers' right to medical care and civil rights litigations for the rights of persons in prisons and police custody. Litigations on emergency medical care, though miniscule in number, have significantly exposed systemic inadequacies in the area of life-saving care. These include delay in or denial of the provision of care, insensitivity and personal/professional apathy on the part of medical professionals, especially towards patients from socially disadvantaged communities. In a few cases, petitioners from the middle and upper strata of society have spent several years fighting for justice. Given a judicial system which is said to be difficult to access (6), there are manifold instances in which citizens have either not reported the injustices suffered, have not accessed judicial avenues, or have given up midway.

Preservation of life and saving life – absolute constitutional obligation

The ethical dimensions of the jurisprudence in this area are founded on and integral to the principle of the "right to life and dignity", enshrined in Article 21 of the Constitution. Building on this principle, the SCI judgments have established that the ethical duty to "save or preserve life" is the unequivocal jurisprudential principle. The courts have reiterated that it is binding both on the State as well as the medical profession. In the *Parmanand Katara* judgment, access to emergency care was declared a fundamental right. Critics described it as a symbolic and "paper right" (17), as no pathway was suggested to realise this right.[1] Nonetheless, it served as a launching pad for the further evolution of healthcare

jurisprudence. In a particular litigation the Bombay HC applied the principle of "saving life" to public services, specifically in the case of the railways. It issued a series of directives for the establishment of an emergency response and care system (22).The most important outcomes of this litigation were that the responsibility of the railways was extended to providing treatment to patients in railway hospitals, and that the railways were directed to save the lives of *all* accident victims within the railway premises (inclusive of those travelling without tickets).

A review of the litigations shows that it is with respect to medico-legal cases (largely accidents) and persons in police custody that significant ethical violations take place. In the case of accidents and trauma, the lack of timely emergency care has resulted in many deaths. Due to the medico-legal nature of the cases and fear of harassment by the police and courts, bystanders do not come forward to help the victims. In 2016, following a PIL filed by the SaveLIFE Foundation in 2012, the SCI took steps to usher in another law with respect to accidents and emergency care by asking the Central government to formulate guidelines for the protection of Good Samaritans (26) from the police or other authorities[2] (27).The question was raised in Parliament by Santosh Ahlawat, an MP (28). The issue of protecting doctors from legal hassles in medico-legal cases so that they can provide immediate care to patients in need of emergency life-saving care has also been addressed in an important order (17).

People in State custody, such as those in police or judicial custody, State-run asylums and prisons, face double jeopardy– they are subjected to torture, ill-treatment and abuse, and are also deprived of adequate medical care. In *Poonam Sharma vs. Union of India,* the Delhi HC (24) reinforced the constitutional obligation of policemen and doctors to treat the injured in medico-legal cases. The irrefutable nature of this obligation of the State is confirmed by Article 32 of the Constitution, which provides for access to justice as a fundamental right.

> ... *In the context of the Constitutional obligation to provide free legal aid to a poor accused, this Court has held that the State cannot avoid its constitutional obligation in that regard on account of financial constraints* (29). *The said observations wouldapply with equal, if not greater force in the matter of discharge of the constitutional obligation of the State to provide medical aid to preserve human life.* (18: pp 9–10)

Duty of care as the foremost obligation of the medical profession

While the jurisprudence described in the previous section refers predominantly to the State and its instrumentalities, the "duty of care" is seen as the complementary principle that is applicable to the medical profession and healthcare providers. Under Article 21 of the Constitution, this principle is characterised as being "total, absolute and paramount" (17: 1005–7).While it is distinctly articulated that the "duty of care" is binding on State-run government hospitals and the medical officers employed in them (18: p 5), it is also described as being unequivocally applicable to all medical professionals, both in public and private healthcare institutions (20: pp16–- 21).

> *Whether the patient be an innocent person or a criminal liable to punishment under the laws of the society, it is the obligation of those who are in charge of the health of the community to preserve life so that the innocent may be protected and the guilty may be punished*. Social laws do not contemplate death by negligence [as being] tantamount to legal punishment (emphasis added). *Every doctor, whether at a government hospital or otherwise, has the professional obligation to extend his services with due expertise for protecting life*. (17: pp1005–6)

The legal framework for the duty of care as a binding ethical and constitutional principle was provided by the SCI in a judgment which declared the Code of Medical Ethics (30) as the prevailing law for the medical profession (17: 1005–6). In a sense, this provides medical ethics with the backing of legal authority in India.

Ethical implications of breach of "duty of care"

The jurisprudence contains a clear reference to the implications of breaching the principles of *saving life* and the *duty of care*. It is stated that the failure to provide timely medical treatment to a person in need of emergency care is a violation of the right to life, guaranteed under Article 21of the Constitution (23,18).Subsequently, such reasoning played a role in bringing the medical profession under the Consumer Protection Act (CPA), 1986. For almost a decade, the medical profession, represented by medical associations, resisted the efforts to bring healthcare professionals, in general, and doctors, in particular, under the scope of the CPA 1986. In 1995, a historical breakthrough was made in the case of *Indian Medical Association vs V.P. Shanta,* in which patients availing themselves of healthcare services were defined as "consumers" and healthcare was defined as a "service" under certain conditions[3](25).

It is worth noting that such legal and constitutional provisions have yet to be translated into better and ethical care for patients, especially those from disadvantaged and vulnerable communities. The legal provisions have not been supplemented by any specific legislation that defines the doctor–patient relationship or institutionalises binding protocols for the protection of patients' rights. The conditional and legal definition of a patient merely as a "consumer" under the CPA is not sufficient, at least in emergency care situations. The patient is usually in critical condition, unaccompanied by a legal guardian and not in a state to make a choice/decision on their own. Besides, unlike their counterparts from the middle and upper classes, patients from the disadvantaged communities are not covered by health insurance and when they turn to private hospitals because of the malfunctioning of public hospitals, they do so at the risk of becoming poorer owing to the high medical expenditure they must incur. The situation needs to be remedied by suitable legislation, which was recommended by the 201st Law Commission's report on emergency healthcare (31). This was the commission's only report on issues relating to healthcare. It recommended

that Parliament make emergency care a fundamental and institutionally (both public and private) accessible right through suitable legislation. A senior medical professional and expert on medical ethics underscored the need for such legislation:

> *Having a programmatic aspiration in law is one thing and having an enabling law which actually creates a system and makes it deliver is totally different… you need emergency care. If the doctor is not available, you cannot go to complain... if you do not get what is defined in a primary health centre, then it should be justiciable. But the same system has to create a referral system […] at what level what services should be available. Unless you define it by law, you will not be able to guarantee it.* (32)

In the face of the gaps in policy and legal gaps that prevent the effective enforcement of professional duties, the ethical principles of "saving life" and "duty of care", backed by the jurisprudential mandate, can be potent instruments to impel the medical profession to provide ethical care to patients. The legal overtones of this ethical duty were strongly reinforced in a judgment stating that "medical professionals cannot refuse the duty to care" (21). Onthe basis of legal reasoning, the NCDRC clarified that a doctor is not compelled to treat each and every patient under normal circumstances. However, leaning heavily on medical ethics and on the ground that it is the doctor's ethical duty to treat patients, it affirmed that in emergencies, the doctor was bound to treat the patient and could not delay the treatment (for reasons such as non-payment or delay in payment of fees).

Discussion

Historically, the jurisprudence on emergency medical care, which closely intersected ethical principles, laid the foundation for the evolution of healthcare litigations in India in the 1980s. It served as a bridge for the courts to apply the right to a dignified life and the constitutional obligation of the State to save life in subsequent litigations concerning the medical profession, and private and public healthcare providers. It also facilitated the crafting of healthcare jurisprudence and the declaration of healthcare as a fundamental right.

In addition, ethics jurisprudence, an ethical reading of the jurisprudence on emergency medical care, opens up avenues to recalibrate the various contours of health rights and the policy framework. The significance of ethics jurisprudence can

Table 1 Ethical-jurisprudential principles in emergency care litigations and policy outcomes

Jurisprudential principles	Policy outcomes
Accidents, delay in or denial of care – public healthcare institutions	
• "Saving life" or 'preservation of human life' is the constitutional obligation of a welfare state. • Providing adequate medical facilities is the primary duty of the government in a welfare state. • The doctor's obligation is total and absolute. • Preserving life is an "absolute and non-negotiable" duty of medical professionals under Article 21. • This duty is binding both on the government and private doctors. • Failure to provide medical treatment is a violation of the right to life.	• Emergency medical care articulated as part of the right to life(fundamental right) • Protocols for emergency care formulated • Private hospitals cannot refuse to provide emergency care • 201st report of the Law Commission suggested "emergency care law"
Public enterprises and accidents	
• "To save life" is cited as the key responsibility. The responsibility extends to all victims of mishaps within the railway premises • The responsibility of the public authorities (here, railways) in providing life saving medical care to the injured is fixed and absolute.	• Coverage of medical care expanded from only authorised passengers to cover all citizens meeting with accidents in railway premises at the cost of the railways
Private hospitals and medical professionals	
• Duty of care is the supreme obligation of doctors. • The ethics of the medical profession is upheld and in emergencies, doctors cannot delay, refuse or discontinue service if there is delay in payment or non-payment.	• The constitutionality of the "duty of care" as a professional and ethical duty established • Right to seek parallel remedies in tort and private law upheld
Public authorities, custody and emergency medical care	
• Not providing adequate medical care is a violation of the right to life. • The police and doctors are under a constitutional obligation to provide medical care. • The preservation of life is a statutory obligation.	• Non provision of emergency medical care to persons in State custody (prisons, police stations) by authorities in charge declared a violation of right to life • Negligence by State authorities is a violation of right to life
Medical care and policies	
• Saving life is a service of paramount importance. Citizens who offer to save lives should not be harassed for medico-legal reasons.	• Good Samaritan guidelines sanctioned by the SCI as standing orders, endorsed by the Ministry of Road Transport and Highways

be gauged by its contribution to the historical evolution of healthcare jurisprudence in India and the potential it holds for guiding various actors in the current policy ecosystem.

The private medical sector is vital to the realisation of the right to healthcare in India. The fact that private healthcare institutions have a non-negotiable and supreme duty "to provide" and "not to deny" emergency care (18) gives policy-makers an opportunity to cover a large range of private healthcare providers under the regulatory policy framework. This is bolstered by the constitutional and legal provision that the violation of the ethical principle of "saving life" is a breach of a fundamental right.

The suspension of the administration of the Medical Council of India and the fact that the council was placed under the supervision of the court-mandated supervisory Lodha committee illustrates the collapse of the moral fabric of the medical profession in India (33). This moral decline is also reflected in unscrupulous profiteering in healthcare that prompts medical malpractice and ethical violations. Many ethical-rational doctors have started voicing concern over the way that medical professionals are leaving their ethical objectives behind (34). Most of the experts and petitioners interviewed voiced concern over the ethos of medical practice, which, according to them, was alarmingly unethical. A senior practising surgeon advocating for ethical-medical practice stated that the overall atmosphere of medical practice promotes a lack of ethics and irrationality.

> *… problem, as it seems to me, is that there is complete lack of ethical space … though the institutions themselves [sometimes] encourage ethical behaviour, no hospital encourages ethical behaviour. In fact, the private sector in India encourages unethical behaviour, and there are no good role models and no peer pressure, so somebody who's kind of new on the fence feels within a few years that this is the way to go – transgress the ethical tenets, whatever they are*. (35)

Ethics jurisprudence provides medical professionals with a historical opportunity to rebuild their commitment to ethics and patients' care, and also, partially salvage their own tainted image. Quite a few of the respondents felt that the courts had played a positive role in ushering in the necessary changes, both in the medical profession and the healthcare system. A women's rights activist and petitioner in a litigation related to a clinical trial (in the SCI), for example, endorsed the view that the judiciary and courts had the potential to promote ethics in medicine.

> *... the judiciary has been very active and proactive, taking a keen interest in the issue. ...Through the judiciary, it was possible to push certain things of ethics and regulation; to set systems (protocols) [in place]. The functioning of ethics committees, compensation, human rights violations, deaths and ethics violations were severely taken note of by the courts*. (36)

The entrenched class character of Indian society and the State limits the potential for applying the ethical principles underlying the judgements to serve the interests of the poor, and also, to use the courts for such a purpose in the long run. Further, the literature points to the fact that the courts themselves are a part of the bourgeois capitalist structure (37). This explains the class bias of the courts and their lack of interest in enforcing their own judgments in favour of the poor, and the fact that often, they do not give priority to healthcare issues affecting the marginalised (37). The executive (government machinery), which is entrusted with the constitutional duty of the enforcement of judgements, is said to be in collusion with private commercial interests. This is evidenced, among other things, by the lack of political will to regulate the private healthcare sector (33, 38, 39).

Repeatedly running to the courts is not an option for the poor, since they do not have adequate financial resources, political clout and influence over the judiciary. The class bias is evident also when one considers that some people are able to move the courts and obtain systemic outcomes by exerting influence over the executive. The upper middle class, for example, managed to use the emerging ethics principles to prevail over the judiciary in the "Good Samaritan" PIL. In the case of highway and road accidents, in which deaths occur due to the apathy of bystanders, the SCI issued directives that the Ministry of Road Transport and Highways (MRTH) accepted. In contrast, the principles which emerged from the struggle of a labour union over the denial of medical care to an agricultural labourer, who had suffered injuries while falling off a running train, have yet to be translated into a systemic change (18). Instead, increasing privatisation and the lack of commitment to provide basic healthcare to rural and less advantaged populations have only resulted in the repetition of such incidents (40). Despite the Law Commission's recommendation for an emergency care law in India, public sector hospitals have made no provision for such emergencies and private sector hospitals have turned a blind eye to the guidelines (31). Curiously, almost 20 years after the *Paschim Banga Khet Mazdoor Samiti* case, the discussion on the issue of emergency care has shifted from the healthcare system to the healthcare of individuals belonging to a different class in "the Good Samaritan" discourse. This discourse has been pushed into the public imagination without any reference to the accessibility and availability of emergency care for the disadvantaged; it seems sufficient that such care is available, through medical insurance, to the upper middle class, who continue to disregard its inaccessibility to the underprivileged[4](41). On its part, the MRTH has responded by drafting the Road Transport and Safety Bill, 2014 – a response which was not forthcoming even when the Law Commission made such a recommendation in favour of the rural masses and the poor.

However, many progressive judgments, such as those analysed in this paper, have turned out to be of merely symbolic value or infructuous in the long run due to their vagueness and the lack of specific directives. This has hindered the process of their getting translated into systemic practices or institutional mechanisms (42). For example, despite the strongly worded

judgments, private healthcare establishments routinely deny admission to poor patients, citing moot reasons. Similarly, the policy directive to provide free services to poor and indigent patients – applicable in private charitable nursing homes in some states – is flouted flagrantly though it has been upheld in several court judgments (43). A major lacuna in these judgments is the failure to specify the consequences that medical professionals and healthcare providers would face in case of breach of the court's directives. For the translation of progressive judgments and ethical principles into entitlements to patients, a comprehensive enabling law that creates systemic mechanisms for the use of ethical protocols in healthcare provision would be a positive step forward.

Conclusion

Ethics-compliant healthcare in India can be revitalised on the basis of the core of ethics, encapsulated in the Code of Medical Ethics and reinforced through ethics jurisprudence. Several policy measures, including a comprehensive law to institutionalise ethical principles for upholding the right to healthcare, would be required for streamlining ethics in the public and private healthcare systems. Most importantly, medical professionals themselves would have to show resoluteness in resurrecting and restoring the profession to its noble ethical goals of patient care and mitigation of suffering. Ethically sensitive, equitable and justice-oriented healthcare for the disadvantaged requires not only determination on the part of the medical profession, but also a strong political will.

Competing interests: *None declared.*

Notes

[1] In *Pt. Parmanand Katara vs Union of India and Ors*., 1989 SCR (3) 997, though a profound legal reasoning regarding the right to health as a fundamental right was developed, the Court did not grant any relief to the family of the person who had died. It, however, directed the national media, as well as the High Courts and sessions judges, to give adequate publicity to the decision in this case.

[2] The guidelines include several clauses on the respectful treatment of Good Samaritans, on providing them with protection from harassment when they help save the lives of accident victims and also, if they agree to become witnesses in medico-legal cases later. The guidelines specify that the superintendent or deputy commissioner of police concerned is responsible for ensuring that all the relevant procedures are implemented throughout his/her jurisdiction. (It must be noted that the victim is assumed to be of the middle or upper middle class as it is presumed that he/she is admitted for treatment).

[3] For a detailed discussion on the various conditions under which healthcare services are considered legally defined as "services" to which patients are entitled as "consumers", go through *Indian Medical Association v. V P Shanta* 1996 AIR 550, vide pp. 4–19.

[4] The initiatives of the SaveLIFE Foundation, which is Delhi-based, include creating public opinion and carrying out active advocacy with the government, for example, conducting media campaigns, advocating with members of Parliament, walking for safe roads, lobbying for road safety laws, petitioning the health minister, and using research and the social media for pushing their agenda.

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Healing ministry and palliative care in Christianity

S STEPHEN JAYARD, NISHANT A IRUDAYADASON, J CHARLES DAVIS

Abstract

Death is inevitable, but that does not mean it can be planned or imposed. It is an ethical imperative that we attend to the unbearable pain and suffering of patients with incurable and terminal illnesses. This is where palliative care plays a vital role. Palliative care has been growing faster in the world of medicine since its emergence as a specialty in the last decade. Palliative care helps to reduce physical pain while affirming the aspect of human suffering and dying as a normal process. The goal of palliative care is to improve the quality of life both of the patient and the family.

Palliative care resonates with the healing ministry of Christianity that affirms the sanctity and dignity of human life from the moment of conception to natural death. Christianity is convinced that patients at the very end of their lives, with all their ailments and agonies, are still people who have been created in the image and likeness of God. The human person is always precious, even when marked by age and sickness. This is one of the basic convictions that motivate Christians to take care of the sick and the dying. Palliative care is a great opportunity for Christians to manifest God's unfailing love for the terminally ill and the dying.

Introduction

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Pinki Virani thought that she was committing a charitable act by filing a plea in the Supreme Court of India (1) to end the life of Aruna Shanbaug, in a comatose state for 43 years at the KEM Hospital, Mumbai, following a sexual assault while on duty, on November 27, 1973. The Supreme Court turned down Pinki Virani's plea on March 7, 2011. On another occasion, the Supreme Court upheld religious freedom through a judgment on September 1, 2015(2), in the context of a fast unto death. It stated that the traditional Jain practice of *Santhara or sallekhana* was "simply a Jain way of mastering the art of dying, as much as the act of living". Situations like these call for more urgent reflection than ever before on questions such as the fundamental value of human life and what alternatives we have to take care of dying persons when medical treatments become futile[1].

The term "palliative care" is spreading faster in the world of medicine than the names of medicinal drugs. Palliative care provides relief from pain, while affirming life and viewing death as a normal process. It is a system that provides special care and support to help not only dying patients, but also their families cope with the grim situation. This article focuses on the Christian perspective on the access of dying patients, especially those with incurable diseases, to palliative care. It has four parts, the first of which makes a brief attempt to understand human life and the concept of palliative care. Second, the article discusses the justification of the practice of palliative care within the Christian ethics tradition. Third, it considers the sacrament of anointing the sick in terms of a concrete application of palliative care. Finally, it discusses the magisterial teaching of the Catholic church, with a brief reference to the Protestant churches.