ISSN: 2582-6433

INTERNATIONAL JOURNAL FOR LEGAL RESEARCH AND ANALYSIS

Open Access, Refereed JournalMulti Disciplinary
Peer Reviewed6th Edition

VOLUME 2 ISSUE 7

www.ijlra.com

 ISSN: 2582-6433

DISCLAIMER

ISSN: 2582-6433

EDITORIAL TEAM

EDITORS

Megha Middha

Megha Middha, Assistant Professor of Law in Mody University of Science and Technology, Lakshmangarh, Sikar

Megha Middha, is working as an Assistant Professor of Law in Mody University of Science and Technology, Lakshmangarh, Sikar (Rajasthan). She has an experience in the teaching of almost 3 years. She has completed her graduation in BBA LL.B (H) from Amity University, Rajasthan (Gold Medalist) and did her post-graduation (LL.M in Business Laws) from NLSIU, Bengaluru. Currently, she is enrolled in a Ph.D. course in the Department of Law at Mohanlal Sukhadia University, Udaipur (Rajasthan). She wishes to excel in academics and research and contribute as much as she can to society. Through her interactions with the students, she tries to inculcate a sense of deep thinking power in her students and enlighten and guide them to the fact how they can bring a change to the society

Dr. Samrat Datta

Dr. Samrat Datta Seedling School of Law and Governance, Jaipur National University, Jaipur. Dr. Samrat Datta is currently associated with Seedling School of Law and Governance, Jaipur National University, Jaipur. Dr. Datta has completed his graduation i.e., B.A.LL.B. from Law College Dehradun, Hemvati Nandan Bahuguna Garhwal University, Srinagar, Uttarakhand. He is an alumnus of KIIT University, Bhubaneswar where he pursued his post-graduation (LL.M.) in Criminal Law and subsequently completed his Ph.D. in Police Law and Information Technology from the Pacific Academy of Higher Education and Research University, Udaipur in 2020. His area of interest and research is Criminal and Police Law. Dr. Datta has a teaching experience of 7 years in various law schools across North India and has held administrative positions like Academic Coordinator, Centre Superintendent for Examinations, Deputy Controller of Examinations, Member of the Proctorial Board

ISSN: 2582-6433

Dr. Namita Jain

Head & Associate Professor

School of Law, JECRC University, Jaipur Ph.D. (Commercial Law) LL.M., UGC -NET Post Graduation Diploma in Taxation law and Practice, Bachelor of Commerce.

Teaching Experience: 12 years, AWARDS AND RECOGNITION of Dr. Namita Jain are - ICF Global Excellence Award 2020 in the category of educationalist by I Can Foundation, India.India Women Empowerment Award in the category of "Emerging Excellence in Academics by Prime Time & Utkrisht Bharat Foundation, New Delhi.(2020). Conferred in FL Book of Top 21 Record Holders in the category of education by Fashion Lifestyle Magazine, New Delhi. (2020).Certificate of Appreciation for organizing and managing the Professional Development Training Program on IPR in Collaboration with Trade Innovations Services, Jaipur on March 14th, 2019

Mrs.S.Kalpana

Assistant professor of Law

Mrs.S.Kalpana, presently Assistant professor of Law, VelTech Rangarajan Dr. Sagunthala R & D Institute of Science and Technology, Avadi.Formerly Assistant professor of Law,Vels University in the year 2019 to 2020, Worked as Guest Faculty, Chennai Dr.Ambedkar Law College, Pudupakkam. Published one book. Published 8Articles in various reputed Law Journals. Conducted 1Moot court competition and participated in nearly 80 National and International seminars and webinars conducted on various subjects of Law. Did ML in Criminal Law and Criminal Justice Administration.10 paper presentations in various National and International seminars. Attended more than 10 FDP programs. Ph.D. in Law pursuing.

Avinash Kumar

Avinash Kumar has completed his Ph.D. in International Investment Law from the Dept. of Law & Governance, Central University of South Bihar. His research work is on "International Investment Agreement and State's right to regulate Foreign Investment." He qualified UGC-NET and has been selected for the prestigious ICSSR Doctoral Fellowship.He is an alumnus of the Faculty of Law, University of Delhi. Formerly he has been elected as Students Union President of Law Centre-1, University of Delhi.Moreover, he completed his LL.M. from the University of Delhi (2014-16), dissertation on "Cross-border Merger & Acquisition"; LL.B. from the University of Delhi (2011-14), and B.A. (Hons.) from Maharaja Agrasen College, University of Delhi. He has also obtained P.G. Diploma in IPR from the Indian Society of International Law, New Delhi.He has qualified UGC – NET examination and has been awarded ICSSR – Doctoral Fellowship. He has published six-plus articles and presented 9 plus papers in national and international seminars/conferences. He participated in several workshops on research methodology and teaching and learning.

ISSN: 2582-6433

ABOUT US

INTERNATIONAL JOURNAL FOR LEGAL RESEARCH & ANLAYSIS ISSN 2582-6433 is an Online Journal is Monthly, Peer Review, Academic Journal, Published online, that seeks to provide an interactive platform for the publication of Short Articles, Long Articles, Book Review, Case Comments, Research Papers, Essay in the field of Law & Multidisciplinary issue. Our aim is to upgrade the level of interaction and discourse about contemporary issues of law. We are eager to become a highly cited academic publication, through quality contributions from students, academics, professionals from the industry, the bar and the bench. INTERNATIONAL JOURNAL FOR LEGAL RESEARCH & ANALYSIS ISSN 2582-6433 welcomes contributions from all legal branches, as long as the work is original, unpublished and is in consonance with the submission guidelines.

www.ijlra.com
Volume 2 Issue 7 | April 2023
ISSN: 2582-6433

DNAR AND CONSENT IN CONTEXT OF MEDICAL NEGLIGENCE

AUTHORED BY - SHREYA SHETTY

ABSTRACT

The act of taking a life is only permissible under the law. The application of "due process of law" extends beyond the context of the death penalty. The concept of "due process of law" refers to the requirement that any law which infringes upon the rights of individuals must undergo a set of procedural safeguards to verify its compliance with the constitution. In certain instances, the entitlement to a life of dignity encompasses the entitlement to end one's life. The act of "mercy killing" or euthanasia, which involves intentionally ending the life of an individual to protect their interests, can manifest in various ways. The practise of euthanasia and other forms of "mercy killing" exhibit significant variation across different nations. Euthanasia is a medical practise that is legally permitted in certain countries, while in others it remains illegal. This research aims to delineate the various manifestations of euthanasia. The phrase "Do not attempt to resuscitate" is a commonly used medical term, however, it remains an unregulated form of assisted suicide. Prior to the decriminalisation of passive euthanasia, India had implemented a Do Not Resuscitate (DNR) policy. The legislation lacks regulation. Such arrangements fail to adhere to legal protocols. The present study explores the concept of DNAR as a form of legally sanctioned euthanasia or assisted suicide. The research investigates the validity of DNR. The text examines the interconnections among the patient's entitlement to life, the ethical principles of the medical profession, and their obligation to this matter.

Keywords: Euthanasia, DNR, due process of law, Right to die

ISSN: 2582-6433

INTRODUCTION

The state is obligated to fulfil certain negative responsibilities when it comes to fundamental rights; nevertheless, the ever-evolving concept of justice has necessitated that these responsibilities be interpreted in a proactive manner in order to protect the interests of citizens. A fairly strict reading of Section 21 of the Indian constitution was accepted by the constituent assembly. This interpretation stipulated that no one's life would be taken away from them unless it was in accordance with the proper legal procedure. The term "due process of law" does not just apply to carrying out the judicial equivalent of the death penalty. The phrase "due process of law" means that if there is a law that infringes on the rights of citizens, such law will be preceded by a system of acts and checks in order to ensure that it is constitutional. In a few different situations, the right to life with dignity has been expansively interpreted to encompass the right to end one's life. This introduces the idea of "mercy killing" into the conversation. There are varying degrees and types of what are collectively referred to as "mercy killing," which refers to the act of causing a person's death in order to protect their interests. However, the legality of euthanasia and other forms of "mercy killing" varies greatly from country to country. Some nations have made mercy killing lawful by classifying it as a valid medical practice, while others have recognised it as an acceptable exception, while yet others continue to maintain that it is contrary to the law. In this article, we will attempt to trace the history of mercy killing and its many different manifestations. The phrase "do not attempt to resuscitate" is commonly used in the medical field; yet, it continues to be an unregulated kind of assisted suicide that is not precisely defined by legislation. Do Not Attempt Resuscitation, often known as DNAR, is a procedure that is commonly used in specific circumstances to prevent ineffectual CPR and to protect the dignity of the patient. After discussing the matter with the patient or with the patient's surrogate, the treating physician, who is familiar with the patient's medical state, should decide whether or not DNAR should be performed. While ordering DNAR on the patient's medical case record, every effort should be made to treat the underlying condition and the patient should continue to get the highest quality medical care that is currently available. Before the decriminalisation of passive euthanasia in India, the DNR practise had been been in place there for some time. Despite this, there is no regulation of the act. In such arrangements, there is no respect for the law's prescribed procedures. This paper is an exploratory attempt to identify the validity of DNAR as a kind of legal euthanasia or any other form of assisted suicide or killing. The study has been written as an exploratory attempt to find the validity of DNAR. In addition to this, it makes an effort to address the intersectionalities that exist between

ISSN: 2582-6433

the right to life of the patient, the code of ethics that the medical community is required to adhere to, and their responsibility to a cause of this nature. The purpose of this study is to investigate whether DNAR is a type of mercy or a technique that should be prohibited.

Indian cultural context

Joseph Fletcher, a well-known philosopher, has been a proponent of euthanasia ever since the early 1930s, according to a piece that he wrote in which he argues that any reasonable society would want to exert logical control over the act of ending human life.

Every individual should have the right to die with dignity, which includes the option to choose when they will pass away and the right to get medical and pharmaceutical assistance to die painlessly. This right should be given to everyone. Doctors, nurses, and pharmacists cannot be held criminally or civilly liable if they assist a patient in exercising their rights to free speech and assembly without interference.

A clause of the European Convention for the Protection of Human Rights and Fundamental Freedoms safeguards individuals against intentional deprivation of life. The quality of life is not addressed, and it is clear that ending a person's life at his or her own request is unacceptable. The phrase "right to life" can also mean "right not to be killed" in the context of medicine, with the emphasis on survival rather than medically assisted death. Many, however, understand this to mean that patients always have the right to cardiopulmonary resuscitation, regardless of clinical circumstances.[1] Extending this to all conceivable interventions at the life-death interface could have catastrophic repercussions for the medical profession.

Katherine Young, in her investigation of the traditional Hindu perspective on euthanasia, makes the observation that, if one were to take today's emergent definition of euthanasia with its technical insistence on medically defined cases of terminal illness and its circumscribed meaning of a doctor actively killing a patient on compassionate grounds, given due process of decision making, then, by definition, he would be hard pressed to find equivalent situations in the past and in other pre-

[1] BMJ: British Medical Journal , Jun. 11, 2005, Vol. 330, No. 7504 (Jun. 11, 2005), pp. 1388-1389

ISSN: 2582-6433

moderator societies.[2] Young employs the antiquated definition of euthanasia as "freedom to leave," which allowed the terminally ill and those with a hopeless outlook to end their life, in order to make it easier to conduct a historical and comparative analysis. Her research sheds light on how voluntarily ending one's life in specific circumstances, such as old age or illness, was common in India for a significant portion of its history, but was finally eradicated in the early modern period. In comparison, euthanasia, in the sense of the freedom to leave, was rarely found in the western world after the Greco-Roman period. However, the merits of euthanasia are becoming increasingly debated in today's society, as the practise of withdrawing treatment from patients in hospitals becomes more common and as the discussion over compassionate murder continues. It is believed that Jainism was the first religion to approve of the practice of a religiously sanctioned, self-willed death. This practise, which was known as sallekhana and involves fasting to death, was practised by Jainists. While it is true that suicide is unequivocally wrong, it is becoming more acceptable to die a heroic death in battle, to die a self-imposed death because one is enlightened or has the desire to become enlightened, or to die a self-willed death due to severe old age or poor health.

Although the Buddha made an effort to avoid accepting the heroic (self-willed) dying that was so prevalent in Ksatja circles, he did allow self-willed death for the exceedingly ill as an act of compassion; in other words, he approved of euthanasia for those who were suffering from a terminal illness. It is possible that the Brahamanical willingness to ritualize the withdrawal of the king (and his wife) into the forest as a manner of abdicating the kingdom in old age may have set the stage for religious self-sacrifice and self-willed death as a way to enter heaven in Hinduism. Aside from this, euthanasia is permitted when a person is no longer able to execute daily dharmic responsibilities for themselves, such as purifying the body. This can be accomplished by jumping from a cliff into water, jumping into fire, or walking oneself to death, among other methods. 1 Within the framework of Hinduism, euthanasia was classified as a form of religiously motivated self-directed dying. As a result, it was never considered a case of one person showing compassion for another by taking their life. Therefore, the ability of the I to bring about his death was normative for the acceptance of eut in Hinduism; nevertheless, it may be argued that contemporary western civilizations do not share the same r worldview as Hinduism.

[2] 0. Harold G. Coward, "Introduction" in Harold G Coward et al. (eds.), Hindu Ethics, id. at 5.

ISSN: 2582-6433

There is a growing consensus in the west that the term euthanasia should refer to the concept of compassionate murder in medically defined cases of illness. This involves the medical profession in the active killing of the given due process of decision making. While the process of legal definition making is not yet complete, there is a growing consensus that the term euthanasia should refer to this. It has been suggested that euthanasia should be differentiated, on the one hand, from homicide (culpable or inculpable), and, on the other hand, from situations in which the withdrawal of treatment, pain relief that may result in death, aiding suicide, and euthanasia itself.

Right to die in India

In India, where euthanasia and physician-assisted suicide are both strictly prohibited, the legislation is a sleeping giant, despite being active in other nations. A physician who provides a patient with lethal medications so that he might terminate his life is liable as an aider in suicide. In India, both suicide aid (section 306 of the Indian Penal Code) and suicide attempt (section 309 of the Indian Penal Code) are criminal offences. In many nations, including the United States and the United Kingdom, attempted suicide is not a crime. However, a physician who attempts to kill a patient at the patient's request will fall under exception 5 to section 300 of the Indian Penal Code and will be held accountable under section 304 of the Indian Penal Code for culpable homicide not amounting to murder. Instances of non-voluntary and involuntary euthanasia would be omitted by the first proviso to section 92 of the IPC, rendering them illegal. In its 42nd report, the Law Commission of India suggested the repeal of the rule as early as 1971.[3]The section had been deemed harsh and unjustified by the commission.

In Gian Kaur v. State of Punjab 41, the constitution bench of the Supreme Court ruled that neither euthanasia nor assisted suicide are legal in India. In P. Rathinam v. Union of India, an earlier two-judge bench ruling of the same court was overturned by this judgement. 42 In Gian Kaur's case, the court determined that article 21 of the Constitution's right to life did not include the right to die. In this instance, a corollary was drawn between euthanasia and suicide (in legal terminology and obiter dicta). In this instance, the Supreme Court upheld the House of Lords' decision in the Airedale case43 and noted that euthanasia could only be made legal by legislation. Although it is against the law to engage in active euthanasia in India, passive euthanasia is permitted there. Aruna Ramchandra

[3] 37 Richard Miniter, The Dutch Way of Death, Opinion Journal from The Wall St

ISSN: 2582-6433

Shanbaug v. Union of India,44 which was heard by the Supreme Court of India on March 7, 2011, resulted in the legalisation of passive euthanasia, also known as the removal of life-sustaining treatment to people who are in a vegetative state permanently on life support.

Assisted Sucide or mercy killing

The two most important cases ever heard in the United States to consider the question of whether or not a person has a constitutional right to aided suicide originated as challenges to state laws that prohibited physician-assisted suicide and were brought by individual patients who were nearing the end of their lives and the doctors caring for them In the case of Washington v. Glucksberg , the court Vacco v. Quill Two state supreme courts declined to invalidate state statutes as a result of the case. prohibiting assisted suicide on the basis that such practises breach privacy laws in their respective legal systemsthe constitutions of the individual states. In the case of Glucksberg, the court determined that the claimed It is not a fundamental liberty interest to have the right to receive assistance in committing suicide , it is not safeguarded by the Constitution's Fourteenth Amendment's Due Process Clause. In the case of Vatco, the court decided that the state of New York's prohibition on providing assistance to suicidal individuals violated the equal protection clause of the United States Constitution. The court in Gluck made the distinction between refusing to take medication that could save your life and taking medication that could kill you. "with the SECO submission that stopping or refusing life-saving medical treatment more nor less than assist" was not accepted by the court.[4]

The Indian Penal Code (IPC) is where the issues of PAS, active and passive euthanasia, and euthanasia in general are addressed. This is where the legal status of PAS and euthanasia in India can be found. At the very least, active euthanasia is considered a violation of Section 304 of the Penal Code 1860, which states that the conduct constitutes a punishment for murder under Section 302. (punishment for culpable homicide not amounting to murder). Whoever administers the lethal dose is what differentiates euthanasia from physician-assisted suicide; in euthanasia, this is done by a doctor or by a third person, whereas in physician-assisted suicide, this is done by the patient himself. Euthanasia and physician-assisted suicide are two different forms of the same practise. In India, the PAS would be considered an act of abetment of suicide, which would fall under Section 306 of the Indian Penal Code (abetment of suicide). Therefore, anyone who is prepared to explore euthanasia or

[4] Journal of the Indian Law Institute , APRIL-JUNE 2012, Vol. 54, No. 2 (APRILJUNE 2012), pp. 196-231

ISSN: 2582-6433

PAS in India needs to go via the courts of law, and the courts have absolutely not reached a clear verdict on this topic that would allow a PAS to go ahead.

Arguments between those who embrace the concept of euthanasia and PAS and those who oppose the concept have always existed and will continue to exist in the future. Some people believe that hospitals do not take into consideration the patients' preferences, particularly when the patients are suffering from life-threatening, debilitating, or conditions that do not respond to treatment.[5] The new legislation that could be enacted in the event that PAS is authorised will almost certainly result in a shift in the prevalent medical culture. Because psychiatrists always have to deal with concerns concerning patients' mental capacities, this topic is becoming an increasingly pressing concern for them. It is necessary to do empirical study on the issues of perceptions and attitudes concerning euthanasia and PAS in India among large numbers of experts and the general public in order to arrive at relevant findings on whether or not euthanasia and PAS should be legalised.

Consent

Throughout the entire ordeal of holding the doctor liable for any form of action or omission done by him under the Indian penal code, question arises as to whether the consent of the patient falls under inspection while determining the liability attached to the consequences of the act. It's possible that consent is the only premise that unites all of today's health care provisions, but it's certainly one of them. It also stands for the ethical and legal embodiment of the fundamental right to have one's own autonomy and to determine one's own course of action. If a medical practitioner attempts to treat a patient without the patient's proper consent, then the practitioner will be held accountable under tort law as well as criminal law. A civil wrong known as a tort can result in a party being entitled to seek compensation from the person who caused the harm. Both financial restitution (in the form of a civil fine) and even jail time are possible outcomes (in criminal). To get started, the patient has the option of bringing a tort claim against the medical practitioner for trespass to person. There is also the option of bringing a negligence claim against the medical expert. There is a theoretical chance that criminal charges could be brought against an individual for assault or battery in certain extreme instances. The act of directly and either intentionally or negligently causing some physical contact with another

[5] Indian J Psychol Med. 2013 Jan-Mar; 35(1): 101–105.

ISSN: 2582-6433

person without that person's consent is often understood to be the definition of the crime known as battery. If a person has either explicitly or implicitly given their permission to be touched, then there is no such thing as battery. If there is a flagrant disregard for the patient's bodily autonomy—for example, if a patient's organs are removed without his consent—then a doctor might be held accountable for a criminal violation, but this is an extremely unusual occurrence.

There are two more important facets that need to be taken into consideration: first, valid consent can only be gained from a patient who is competent to assent, and second, such consent must also be informed consent. This is the only way that valid consent can be obtained from a patient. The patient must be endowed with the ability to balance the risks and benefits of the therapy that is being recommended to him in order for him to be considered competent to give a consent that is legally effective. The law operates under the presumption that one attains such a capability upon reaching the age of full maturity in the general population. Due to the fact that the law presupposes that the medical practitioner is in a dominant position in relation to the patient, it is his responsibility to ensure that adequate permission is obtained by giving the patient with all of the relevant information. A consent that is lacking the required information is not a valid consent at all. Unfortunately, the phrase "informed consent" is frequently employed without the appropriate level of specificity.

What is DNAR?

DNR orders, also known as do not resuscitate orders, are instructions that are placed into a patient's medical chart by a physician with the consent of the patient or the patient's surrogate. As was covered in Chapter 2, terminally ill patients suffering from a wide variety of conditions are susceptible to experiencing cardiac or respiratory arrests. The phrase "code" designates the customary response to this circumstance. DNRs, which are often commonly referred to as "no-codes," instruct hospital staff and other caregivers not to attempt resuscitation in the event that the patient experiences cardiac arrest. Even when performed, the chances of successfully resuscitating a patient with cardiopulmonary resuscitation are normally quite low, particularly for elderly people (Murphy et al., 1989). Therefore, "Do Not Attempt Resuscitation" instructions are sometimes known as "DNRs," which stands for "Do Not Attempt Resuscitation."

Due to the fact that DNRs are orders given by physicians, their origins can be traced back to the

ISSN: 2582-6433

clinical tradition rather than the legal history. Therefore, they are more comparable to orders for lab work and medications than they are to legal documents such as wills and powers of attorney that are durable. In addition, many hospitals began providing alternatives for DNR orders long before the legislation required them to do so. However, if the courts take DNRs into consideration when determining whether or not a patient's wishes have been honoured, they could have some bearing on the law. Because the choice to place a DNR in the patient's chart must be made in conjunction with the patient and must reflect the patient's decision to forgo certain life-prolonging procedures, DNRs play a role in advance care planning along with living wills and durable powers of attorney. This is because the choice to place a DNR in the patient's chart must be made in order to reflect the patient's decision to forgo his right to treatment.

Patients consent

Patients should be involved in the determination of DNR orders, challenging the norm of familial determination in the Asian context, according to oncology and palliative care healthcare professionals who believe patients should be involved in at least the discussion of DNR orders, if not in the determination itself. The myriad of responses exemplify the difficulty of making choices regarding matters that are associated with the end of one's life. Consequently, it is necessary to take into consideration the countless biopsychosocial, practical, and ethical considerations that are associated with such deliberations.[6]

Patients and their families may have a difficult time making a decision that is actually in the patient's best interest because DNR orders are highly emotive and may be associated with negative connotations of failure. Concurrently, conversations on a pointless treatment with the false aim of gaining family support for this endeavour may in fact violate the nonmaleficence principle, which states that one should not act in a way that causes harm to another. In addition, if the patient or their family votes against a DNR order, the provision of a futile therapy may in reality be a breach of the physician's overriding duty of care to the patient and their family. This is because the physician's primary responsibility is to the patient and their family. It would be a violation of a physician's fundamental commitment to act in the patient's best interests for the physician to agree to trade patient autonomy for a therapy that would be more detrimental to the patient than it would be beneficial to

[6] Indian J Palliat Care. 2012 Jan-Apr; 18(1): 52–58.

ISSN: 2582-6433
the patient.

Medical Negligence

Question arises as to whether lack of consent of the patient to determine his access will create liability over the doctor ? Would this result in medical negligence? The appropriate treatment and pharmaceutical process according to the standards that should be taken into account by a physician when delivering treatment to his patients are specified in a standard of care. A standard of care is sometimes referred to as a care standard. The level of care provided should neither be extremely high nor extremely low.

In this context, the degree refers to the level of treatment that an average health care worker who has received the same education and experience would provide in conditions that are analogous and located within the same community. This is the most important issue that needs to be answered in situations of medical negligence, and if the answer is "no," and you were injured as a result of the bad care, you have the right to bring a lawsuit for medical malpractice.

In the case of Dr. Laxman Balkrishna Joshi vs. Dr. Trimbak Bapu Godbole and Anr.[7]The Supreme Court ruled that a doctor is obligated to perform certain duties, and that if he breaches even one of those duties, he may be held legally responsible for medical negligence. The Supreme Court's decision can be found here. A doctor is obligated to practise a level of care that is commensurate with the standards established for this profession.

The fundamental aspects of Medical Negligence
(I) there is a responsibility toward patients; (ii) there is a deficiency in duty for patients; (iii) this immediately leads in; and (iv) the patient or their families suffer some kind of damage as a direct consequence of this; the damage could be physical, mental, or financial.

In the framework of DNAR, the act of omission is seen to be an example of a passive action that yet carries responsibility. In the event that the patient is not given the opportunity to participate in the decision-making process regarding his or her medical treatment, the physician has breached the duty

[7] Dr. Laxman Balkrishna Joshi vs. Dr. Trimbak Bapu Godbole and Anr.1969 AIR 128

ISSN: 2582-6433

of care that he or she owes to the patient and the patient will experience a decrease in the quality of service that is provided to them. It is necessary for the physician to be held liable for the loss that was incurred as a result of the lack of care and treatment provided on his behalf. There is an insufficient amount of documentation used in the Indian hotel industry, which makes the DNAR procedure more difficult. A loss is incurred for both the patient and his interests as a result of the absence of recorded consent and the opportunity to consent.

Conclusion

Hospital directives that do not include CPR or advanced cardiac life support (ACLS) are unusual in and of themselves. A patient is required to give their informed permission prior to any medical procedures. Patients need to be informed of both the benefits and risks of the proposed intervention before they may give their consent for it. Under the law, it is possible to be charged with assault and battery for doing something to a patient without first obtaining their agreement. Even if it could save the patient's life, an intervention such as a cancer resection should never be performed on a patient against their will without first obtaining their agreement. However, CPR flips the script on the concept of informed consent. Because an emergency situation arises when the patient is unable to grant consent and there is no time to ask surrogates, medical professionals make the assumption that patients accept resuscitation attempts unless they have previously determined that patients do not want these attempts. As advocated by the American Heart Association (AHA), Boozang proposes doing away with the implied consent method and replacing it with one in which explicit conversations are held with each patient upon admission to the hospital. The idea of consent attached to DNAR is nascent and ever evolving , with the expansion of right to life with dignity and the trend to legalise assisted suicides the idea od consent in death is imminet . The area of law remains unspoken about due to the legal recognition of the right to death under the current legal system. However evolving times need evolving approaches to law and anticipation of probable issues,

ISSN: 2582-6433

Sources:

- https://www.ncbi.nlm.nih.gov/books/NBK233596/
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3701348/
- https://www.mondaq.com/india/human-rights/682770/supreme-court-upholds-passive-euthanasia-issues-guidelines-on-advance-directives-in-landmark-judgement
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4441884/
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7371064/
- https://www.mondaq.com/india/human-rights/682770/supreme-court-upholds-passive-euthanasia-issues-guidelines-on-advance-directives-in-landmark-judgement
- Donald L. Levin & Nancy R. Levin, DNR: An Objectionable Form of Euthenasia, 49 U. CIN. L. REV. 567 (1980).
- Scott R. Cox, The Qualified Right to Refuse Medical Treatment and Its Application in a Trust for the Terminally Ill, 13 J. FAM. L. 153 (1973).