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ARCTURUS - THE NEW OMICRON SUBVARIANT AMIDST COSMIC VIBES

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Arcturus (Arktouros) meaning "Guardian of the Great Bear"; is a giant red star in the Northern Hemisphere of the Earth's sky, the brightest star in the constellation Boötes which will dwindle off as a white dwarf at the end of its life [1]. The Greeks considered it heralding the return of the spring. Around 460 B.C., the Greek physician Hippocrates believed that the position of Arcturus in the sky influenced human health and with its rising in the early spring "diseases often prove critical" [2]. Since then Arcturus has been the subject of close scientific scrutiny denoting a new cosmology of convergence of spiritual and scientific understanding.

According to astrology the clash between mutable signs Pisces (known to rule religion), Virgo (which rules epidemics), Gemini (ruler of short journeys) and Sagittarius (that rules foreigners) has often been a harbinger of problems [3]. The year 2023 shows the storm of Pisces cycles in opposition to Virgo (that rules health and wellbeing) which is rare along with Pluto in Aquarius and is crucial in giving indications of protection from COVID [3]. Retrograde Mercury in Taurus after the full moon on March 7th points to difficult news about COVID [3]. Coincidentally, the period predicted in astrological calculations coincides with

international and domestic travels taken up by people due to the Chinese New Year in China [4]. After facing protests against the Zero COVID policy, China had to drop out its restrictions thus permitting international travel in January which accrued the cases in the country [4]. Following the sudden rise in cases, on March 22nd, 2023, the Arcturus (officially titled XBB.1.16) subvariant of Omicron was classified by the WHO as a Variant Under Monitoring (VUM) [5].

Ever since its origin, the SARS-CoV-2 is mutating, playing games of dodge and duck, evading the hosts' immune system, with its every new variant causing the previous one to dip and dive and gradually wane off. From the Variants of Concern (VOC) viz. B.1.1.7 (Alpha), B.1.617.2 (Delta), B.1.351 (Beta), and P.1 (Gamma) to the Variants of Interest (VOI) B.1.427/B.1.429 (Epsilon), B.1.526 (Eta), and B.1.525 (Kappa) the path of the different SARS-CoV-2 variants can be traced to diverse geographical distribution. The geographical location may have played a pivotal role in the evolution of the viral variants [6]. Owing to its RNA genome, the virus has been evolving and mutating faster [7].

The Omicron (B.1.1.529) which was first reported in November 2021 from South Africa was

designated by the WHO as a Variant of Concern as many labs reported the S gene dropout or S gene target failure thus resulting in improved immune tolerance by the variants and evasion from previously developed antibodies that were circulating in the hosts following vaccination [8]. It is one variant that has mysteriously shown many mutations.

Various theories have been put up regarding the origin of the heavily mutated Omicron strain. Firstly, it might have evolved in a hidden population where it was difficult to conduct nucleic acid tests. Owing to its origin in South Africa from its ancestor variant (EPI_ISL_4652284) discovered on 28 July 2021 showing an extremely rare mutation N856K. [9]. The N856K along with N764K generate two potential cleavage sites for SKI-1/S1P serine protease which is absent in human lung tissues but present in the bronchus and nasopharynx, thus explaining the change of tissue tropism in Omicron and opening wider channels of destruction for the variants in terms of host range and pathogenesis [10]. Secondly, the Omicron may have originated from adaptation in animal reservoirs and transmitted back to humans [9]. Thirdly, its prevalence among the People living with HIV (PLHIV) is suggestive of slower clearance of the virus hence facilitating its continuous mutation [9]. Thus the two synergistic pandemics are exacerbating the damage. The Omicron which was known to have the highest number of mutations had wiped off the Delta variant in 2022 and with the beginning of the new year, the Kraken subvariant of Omicron (which originated in New York between November and December 2022) was held responsible for the maximum infections in the US due to its property of immune evasion [11].

However, later in March, this Kraken subvariant which got its name from the northern European sea giant was spun off by the Arcturus subvariant which may be more infectious than its predecessor.

From being first identified in Mumbai, Maharashtra on the 11th of January 2023 it has now been reported in about 40 countries [12]. As suggested by the scientists at the University of Tokyo it could be about 1.17 to 1.27 times more infectious than the Kraken variant [13]. Arcturus has been responsible for more than 17% of new COVID 19 infections in the U.S. [14] Besides the symptoms caused by the previous strains, the most striking feature of Arcturus infection is the 'pink eye' (conjunctivitis) and high-grade fever along with cough, vomiting and loose stools especially among children [15]. Going by the history of the COVID 19 variants, especially the property of immune evasion and the target population being young and unvaccinated infants, Arcturus subvariant may be a threat to this group of the population.

When Saturn is in Pisces, the energy of the two is known to juxtapose each other and there's difficulty in creating boundaries and structure. The last time Saturn was in Pisces around 29 years back, AIDS had surfaced as the biggest killer of mankind, and the cigarette companies were hit by massive US class action lawsuits [3]. People realized that if they had to survive they had to bring lifestyle changes, getting serious about passive smoking, practicing safe sex by using protective barriers, etc. It's like history repeating itself, passive inhalation of the infectious COVID 19 virus, unless one is protected with N95 masks. Saturn will sail in the Piscean seas from September 2025 through February 2026 before bidding a final adieu to the watery sign [16].

Retrograde Mercury indicates rescheduling and reversals from the first week of April to June first week 2023 in Taurus which is a sign ruling the National and world economy and would fit the aftermath of the wave maybe sending the economy for a toss. As per the latest data, the India–China trade has shown the first signs of a slowdown by a drop of 0.9% in the first half of the year [17]. Despite the border disputes the Indo-China trade had risen sharply over the years. The data indicates China's sputtering post-pandemic economic recovery [17]. Even the Global real GDP is forecasted to come down from 3.3% in 2022 to 2.6% in 2023 and further fall to 2.4% in 2024 [18].

Though the Arcturus is known to show alarming immune evasive properties and transmissibility, the consolation is that the patients have shown milder symptoms that did not require hospitalizations [12]. Even the recent report from the WHO highlighted a decreasing trend in deaths and COVID-19-related ICU admissions and determined COVID-19 to be no longer a Public Health Emergency of International Concern (PHEIC) [19]. Though, the astral calculations indicate its presence till the year 2026. As the virus has shown a tremendous scope of mutations, it may show incidences of outbreaks with new strains which are more infectious due to immune evasion but may not be as fatal. If proper protocols are followed in public places and the use of masks etc. is continued, widespread of the virus can be curbed.

When SARS-CoV-2 hit the world, it gave the feeling of an apocalypse. There has been overwhelming destruction of lives, businesses and education. For those who survived, the memories of the scars they left behind will linger on for a lifetime. However, the pace at which its structure,

pathogenesis, and mutations have been studied is no less. Though, vaccines have been available, the virus has the property of mutating and changing its configuration very fast which has been the major problem in establishing herd immunity and is a domain to be handled yet. The first two waves of the pandemic have taught lessons of cleanliness, avoiding the crowd and bringing lifestyle changes that need to be practiced throughout. According to Delaware Gazette, Arcturus, the "orange giant star", has reached the end of its life [20]. Is it the light at the end of the tunnel and true for the pandemic too? Or it's just the tip of the iceberg? It seems to be a wait-and-watch situation.

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DEMOGRAPHIC AND CLINICAL CHARACTERISTICS OF VERNAL KERATOCONJUNCTIVITIS IN THE TERTIARY EYE CARE CENTRE

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ABSTRACT

Introduction: The study focuses on vernal keratoconjunctivitis (VKC), a chronic allergic eye disease. The introduction highlights that VKC is common in certain regions, such as the Mediterranean, South Africa, India, and South America. The authors aim to investigate the demographic and clinical presentation of VKC patients in their region, which is largely unreported.

Material and Methods: A prospective, hospital-based study conducted in Northern India. A total of 150 patients diagnosed with VKC were included. Diagnosis was based on clinical findings, including typical ocular symptoms and features such as itching, redness, gelatinous limbal thickening, and Horner-Trantas spots. The study collected data on age, gender, presenting complaints, disease duration, personal and family history of allergies, type and grading of VKC, visual acuity, and complications related to the disease and its treatment.

Results: The majority of patients were younger than 10 years, with a male-to-female ratio of 2.2:1. Most patients had disease duration of less than 3 years. Itching was the most common complaint, and the limbal form of VKC was the most prevalent. The severity of the disease varied, with the moderate intermittent form being the most common. Visual acuity was generally good, although complications such as steroid-induced glaucoma and corneal scarring were observed in a small percentage of patients.

Conclusion: The study concludes that VKC predominantly affects children, but it can also occur in adults. The male preponderance and association with allergic conditions, particularly allergic rhinitis, are noted. The authors emphasize the importance of early diagnosis and management of complications, such as steroid-induced glaucoma. Overall, the study provides insights into the demographic and clinical characteristics of VKC patients in the region, contributing to the understanding of this chronic allergic eye disease.

Keywords: Vernal keratoconjunctivitis; visual acuity; demographic; clinical; characteristics

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INTRODUCTION

Vernal keratoconjunctivitis (VKC) is a chronic allergic ocular condition characterized by inflammation of the conjunctiva and cornea. It predominantly affects children and young adults, causing significant discomfort and visual impairment. VKC is considered a severe form of allergic conjunctivitis and is associated with substantial morbidity and decreased quality of life for affected individuals. (1) Several studies have been conducted to investigate the demographic

and clinical characteristics of VKC patients, aiming to improve our understanding of the disease and enhance patient management. Leonardi and Secchi (2003) provided valuable insights into the pathogenesis, clinical features, and treatment options for VKC.(2) Another study in 2004, further emphasized the importance of understanding the clinical grading of VKC and its implications for patient care.(3) Studies focused on the development and validation of tools to assess the quality of life in children with VKC,

highlighting the impact of the disease on daily functioning and well-being. (4-6) Shafiq and Shaikh (2009) conducted a hospital-based study to explore the clinical presentation of VKC and its various manifestations. (7) Moreover, some previous long-term follow-up studies, shed light on the natural course of VKC and its prognosis, providing valuable insights into the disease's evolution and the effectiveness of different therapeutic interventions. These studies have greatly contributed to our understanding of VKC and have helped in tailoring treatment strategies for affected individuals. (1,8) In India, VKC is a significant concern due to the high prevalence of allergic disorders and the potential for severe ocular morbidity. A study at a tertiary eye care center in India to assess the demographic and clinical profile of VKC patients in this region, contributing to the local understanding of the disease. (8) While these studies have provided valuable insights into VKC, it is important to further explore and understand the disease's characteristics and its impact on affected individuals. In this study, we aimed to investigate the demographic and clinical characteristics of VKC patients in a specific population. By prospectively collecting data on patient demographics, clinical manifestations, disease severity, associated complications, and treatment outcomes, Purpose of our study is to look for demographic and clinical presentation of patient from this part of the world where though the disease is highly prevalent but still largely unreported. The findings of this study are expected to contribute to the existing body of knowledge on VKC and improve our ability to diagnose and manage the disease effectively. Furthermore, the insights gained from this research may facilitate the development of targeted therapeutic approaches and preventive strategies for VKC.

MATERIAL AND METHODS

It was a prospective, hospital-based study from May 2022 to October 2022 conducted at a tertiary care centre, Northern India after taking clearance from institutional ethical committee and was according to Helsinki of declaration. A total of 150 patients were identified and diagnosed with

Vernal Keratoconjunctivitis. Diagnosis is made on the basis of clinical findings typical of Vernal Keratoconjunctivitis. Patients presented with itching, photophobia, watering, redness in the eyes and on examination were having limbal gelatinous thickening, horner-tranta spots, papillae in palpebral conjunctiva and conjunctival pigmentation. On follow up patients with inactive papillae, no discharge and complain of itching were diagnosed as having evolution of disease. Vernal Keratoconjunctivitis was categorized into three types: Limbal, Palpebral and Mixed. Palpebral form of Vernal Keratoconjunctivitis was diagnosed as having papillae of more than or equal to 1 mm with minimal or no limbal infiltrate, Limbal Vernal Keratoconjunctivitis as limbal infiltrate with less than 1mm of palpebral papillae and Mixed form having features of both. Grading is done into mild intermittent, moderate intermittent, moderate persistent, severe persistent and very severe disease by the method described by Bonini et al. (6) Shield ulcer and Limbal Stem Cell Deficiency were taken into very severe category. Visual impairment was assessed by means of the World Health Organization criteria for visual disabilities as used by Tabbara et al. (9) We collected all details on age of presentation, age of onset, gender, presenting complaint, duration of disease, perennial or seasonal disease, personal and family history of allergy, medication, type and grading of Vernal Keratoconjunctivitis, fundus examination and complications related to Vernal Keratoconjunctivitis and its treatment. Disease was categorized as perennial where it had frequent recurrences throughout the year and seasonal when acute episode was during particular season. To define the adult onset of Vernal Keratoconjunctivitis, a fixed cut off age of 15 years was chosen, with the assumption that at this age, most patients have already attained their puberty. Those patients who had developed features of Vernal Keratoconjunctivitis in younger age group which persisted after puberty, were excluded from adult onset Vernal Keratoconjunctivitis.

Statistical Analysis:

The collected data were coded and entered into an excel software (Microsoft office Excel 2010) database. Data was analyzed using Statistical

Package for Social Sciences, version 16.0 (SPSS, Inc., Chicago, IL, USA). Information related to demographic and clinical characteristics of vernal keratoconjunctivitis were presented in descriptive statistics like, frequency and percentage.

RESULTS

All the patients were between 1.5 years and 30 years of age. 96 (71.1%) of patients were younger than 10 years. In adult, disease onset was found in 14 patients (10.4%) while disease persisted after puberty in 5 patients (3.7%). A total of 150 patients of VKC presented at centre. The mean age at presentation was 11.5 years \pm 6.5 years. The mean period between the initial onset of symptoms and presentation to this centre was 26 \pm 3.2 months.

Table 1: Gender wise distribution of subjects

Gender	Number of Patients	Percentage (%)
Male	103	68.7
Female	47	31.3

Table 1 depicts that the 103 patients (68.7%) were male as compared to 47 female patients (31.3%). Male to female ratio was 2.2:1.

Table 2: Disease duration of patients

Duration of Disease	Number of Patients	Percentage (%)
< 1 year	60	40.0
1-2 years	55	36.7
\geq 3 years	35	23.3

Table 2 shows that, out of total, 115 patients (76.7%) had duration of disease less than 3 years. Among 115 patients, 60 (52.2%) patients had duration of disease less than 1 year.

Table 3: Symptoms of vernal keratoconjunctivitis

Symptom	Number of Patients	Percentage (%)
Itch	145	94.7
Redness	73	54.7
Watering	62	45.9
Discharge	19	14.7
Photophobia	15	11.1
Pain	8	5.92

Out of the total patients, 24 individuals (16.0%) had a positive family history of allergies, and 20 patients (13.3%) reported a personal history of allergic conditions. Among those with a personal history, the most prevalent allergic condition was Allergic Rhinitis, observed in 8.9% of the patients. This was followed by skin allergy, which affected 4.5% of the individuals, and asthma, which was present in 1.5% of the cases. Table 3 shows that, Itch was the most common complaint found in 142 patients (94.7%) followed by redness in 73 patients (54.7%), watering in 62 patients (45.9%), discharge in 19 patients (14.7%), photophobia in 15 patients (11.1%) and pain in 8 patients (5.92%).

Table 4: Types of vernal keratoconjunctivitis

Types	Number of Patients	Percentage (%)
Limbal VKC	83	55.3
Palpebral	46	30.7
Mixed	21	14.0

Table 4 illustrates that the, 83 patients (55.3%) were presented with Limbal VKC, which was found to be the most common form of disease followed by Palpebral type with 46 patients (30.7%) and mixed type with 21 patients (14.0%).

Table 5: Grading of vernal keratoconjunctivitis based on the Bonini et al classification

Severity Grade	Number of Patients	Percentage (%)
Moderate Intermittent	74	49.3
Moderate Persistent	27	18.0
Mild Intermittent	38	25.3
Severe Persistent	9	6.0
Very Severe	2	1.3

Table 5 shows that, grading of the severity of disease was done on the basis of Bonini et al classification. 74 patients (49.3%) were presented with Moderate Intermittent form of disease which was found to be the most common form, followed by Mild Intermittent with 38 patients (25.3%),

Moderate Persistent 27 patients (18.0%), Severe Persistent 9 patients (6.0%) and Very Severe with 2 patient (1.3%).

Table 6: Visual acuity of patients with vernal keratoconjunctivitis

Visual Acuity	Number of Patients	Percentage (%)
6/18 or better	94	62.7
Less than 3/60	4	2.6
Not assessed	52	34.7

Table 6 shows that, 94 patients (62.7%) were having visual acuity 6/18 or better. 4 patients (2.6%) were having visual acuity less than 3/60. While in 52 patients (34.7%), visual acuity could not be assessed due to younger age of patients.

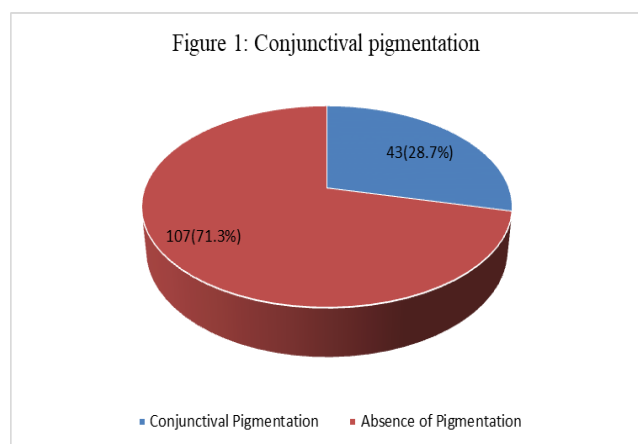


Figure 1 depicts that the, conjunctival pigmentation was found in 43 patients (28.7%) while it was absent in 107 patients (71.3%).

Table 7: Complications and associated findings in patients with vernal keratoconjunctivitis

Complication	Number of Patients	Percentage (%)
Steroid-Induced Glaucoma	13	8.7
Corneal Scar (Healed Shield Ulcer)	4	2.7
Shield Ulcer	2	1.3
Limbal Stem Cell Deficiency	2	1.3
Keratoconus	2	1.3
Cataract	0	0.0

Table 7 shows that, Steroid induced glaucoma was found to be the most common complication with 13 patients (8.7%), which, on treatment, got relieved though we did not find cataract in any of our patients. Corneal scar, which was healed shield ulcer, diagnosed on the basis of its typical location and shape was found in 4 patients (2.7%), while shield ulcer, Limbal stem cell deficiency and keratoconus was found in 2 patients (1.3%) each.

DISCUSSION

The findings of this study provide valuable insights into the demographic and clinical characteristics of vernal keratoconjunctivitis (VKC) patients. In our study, 96 patients (71.1%) were found to be younger than 10 years of age, out of a total of 150 VKC patients who presented at our center. The mean age at presentation was 11.5 years \pm 6.5 years, and the average period between the initial onset of symptoms and their presentation to our center was 26 \pm 3.2 months. Interestingly, we observed that although the disease was more common in school-aged children, the younger age group was equally affected. These findings align with a study conducted by Leonardi et al in Italy from 1996 to 2004, which also reported that 83% of their VKC patients were younger than 10 years of age. (4) In our study, the mean age of presentation was 11.5 \pm 7.1 years. Similarly, in a study conducted by Lambiase et al in South Italy from 2005 to 2006, the mean age of presentation was 13.8 \pm 8.8 years, while the mean age of onset was 7.47 \pm 6.9 years.. (10) Furthermore, in a study conducted by Saboo et al in Southern India over a one-year period, the mean age of presentation was 12 \pm 6.63 years. (8) In our study, the minimum age of onset was 6 months, and the maximum age was 22 years. Conversely, Lambiase et al reported a minimum age of onset of 3 years and a maximum age of 38 years. (10) Although vernal keratoconjunctivitis (VKC) is traditionally considered a disease of childhood that typically resolves at puberty, our findings revealed that 19 patients (12.7%) developed the disease after 16 years of age, when most patients reach puberty. Among these cases, 14 patients (9.3%) experienced adult-onset disease, while 5 patients (3.3%) continued to

suffer from the condition after puberty. Furthermore, Leonardi et al documented 4% of patients above 20 years of age with VKC, while Shafiq et al found 6% of VKC patients in this age group. (4) Saboo et al reported a prevalence of 12% of patients above 20 years of age. The lesser proportion of patients in these studies may be attributed to the fact that they employed a cut off age of 20 years, whereas in our study, we used 16 years as the cut off age. (8) In our study, 68.7% of patients were male, indicating a male preponderance with a male-to-female ratio of 2.2:1. This suggests a potential hormonal influence in the development of VKC, especially in cases of adult-onset disease, where the male preponderance increased to 4:1. Our study aligns with other investigations, revealing a worldwide pattern of male preponderance in VKC. Similarly, in various other studies, the male-to-female ratio has been documented to range from 4:1 to 2:1. (1,8,11,12). Bonini et al discerned a male to female ratio of 3.2:1 in individuals under 20 years of age, whereas it escalated to 4:1 after reaching 20 years of age. (1) Sixteen percent of our patients exhibited a positive family history, and 13.3% exhibited a positive personal history with other allergic conditions. Allergic rhinitis emerged as the most prevalent allergic condition, affecting 8.9% of patients. Studies in India do not indicate a high prevalence of personal and family history, ranging from 1.6% to 6%, as opposed to literature from temperate regions, where the range is between 41.5% to 48.7%, with allergic rhinitis being the most common finding in personal history. (1,2,8,10,13) Moreover, Itching emerged as the most prevalent complaint in our study, with 94.7% of patients experiencing it. This finding aligns with other Indian literature, where Southern India reported 88% of patients with itching. In contrast, a study conducted in a temperate zone by Lambiase et al in Italy found itching/burning in 28.8% of patients. (8,10) These regional differences in itching prevalence could be influenced by environmental factors. Patients in tropical countries, with lesser associations with personal and family history, often presented with the perennial form of the disease, suggesting the potential role of environmental factors in shaping these variations. The current study revealed that

55.3% of our patients exhibited the limbal form of VKC, while 30.7% had the palpebral form, and 14.0% had a mixed form. However, regional differences have emerged from other Indian studies. A study conducted in Southern India reported the mixed form as the most common presentation (71.8%), followed by palpebral (15.6%) and limbal (12.6%). (8) Similarly, another study from Northern India found the limbal form as the dominant presentation (77%), which aligns with our study. (14) Furthermore, data from the temperate zone also displayed a diverse presentation pattern. One study reported 68.5% of patients with the palpebral form of the disease, whereas Bonini et al observed 83.6% of patients with the palpebral form, and Lambiase et al's study indicated the limbal form as the most prevalent (53.2%). (3,4,10) The grading of VKC severity, as per the Bonini et al classification, revealed that moderate intermittent disease was the most prevalent (49.3%), followed by mild intermittent (25.3%), and moderate persistent (18.0%). There were also cases of severe persistent and very severe disease. Notably, regional variations were observed in the severity of the disease. In one study, 32% of patients were diagnosed with severe and very severe VKC, while in our study, this severity was evident in only 7.42% of patients. (8) Regarding visual acuity, the majority of patients (62.7%) displayed a visual acuity of 6/18 or better, indicating relatively preserved vision. However, a small proportion (2.6%) had significantly impaired vision, with a visual acuity of less than 3/60. It is important to highlight that a substantial number of patients (34.7%) could not have their visual acuity accurately assessed due to their young age, presenting challenges in comprehensive visual evaluation in this population. The poor visual acuity observed in these cases was attributed to corneal scarring, keratoconus, and shield ulcer with limbal stem cell deficiency. In our study, we identified two patients (1.3%) with shield ulcers, both associated with palpebral VKC featuring giant papillae. The first patient was successfully treated with ulcer debridement, bandage contact lens, and supratarsal Triamcinolone injection, leading to healing in just three weeks. However, the second patient, who experienced recurrent

shield ulcers, underwent papillae excision with amniotic membrane transplantation but experienced recurrence of papillae after three months. It's worth mentioning that Saboo et al in India reported a prevalence of 3% of patients with shield ulcers, whereas Das et al reported 0.3%. (8,15) Studies conducted in temperate countries have reported an incidence of shield ulcer ranging from 7.7% to 15.3%. Although the majority of their patients with shield ulcer (66.7% to 68.5%) were associated with the tarsal form of the disease, 11.1% to 16.7% of patients were linked to the limbal form of the disease. Limbal stem cell deficiency was detected in two patients (1.3%) in our study. Saboo et al also found 1.2% of patients with central involvement of LSCD and reported two such cases that were successfully treated with limbal stem cell transplantation. In our patient, conjunctivalization did not extend to the centre of the cornea, and therefore, we opted for medical management. We identified one patient with keratoconus. However, corneal topography was not performed regularly in every VKC patient. Das et al reported keratoconus in 1.36% of patients, while Leonardi observed it in three patients. Interestingly, none of these studies conducted corneal topographies on a regular basis. Out of the 150 patients, 90 individuals (60%) demonstrated significant improvement with the treatment, which mainly comprised antihistamines with or without topical steroids that could be gradually tapered. For 46 patients (31%), a regimen involving steroids with or without Tacrolimus .03% ointment was necessary, requiring a more extended period of steroid administration. Among the patients, 8.7% developed steroid-induced glaucoma, making it the most common complication. However, appropriate management led to relief from glaucoma. Other complications such as corneal scar, shield ulcer, limbal stem cell deficiency, and keratoconus were less frequent, affecting a smaller proportion of patients. Saboo et al demonstrated a 4% incidence of steroid-induced glaucoma in their patients. Among these, six patients necessitated trabeculectomy, and one patient required trabeculotomy along with trabeculectomy. (8) Conversely, none of our patients exhibited intractable glaucoma. Bonini et al, on the other

hand, reported a 2% occurrence of steroid-induced glaucoma in their study.(1) In our study, we did not find cataract in any of our patients. Saboo et al found cataract in 6.19% of their patients,(8) while Leonardi et al observed cataract in one of their patients. (4) We found corneal scar in 4 (2.7%) of our patients. While Saboo et al found corneal scar in 11.11% of their patients. (8) The presence of conjunctival pigmentation is a notable clinical finding in VKC patients. In our study, none of the patients were found to have cataracts. However, Saboo et al identified cataracts in 6.19% of their patients, (8) while Leonardi et al observed cataract formation in one of their patients. (4) We observed corneal scars in 4 (2.7%) of our patients, whereas Saboo et al noted corneal scars in 11.11% of their patients. (8) The presence of conjunctival pigmentation emerged as a notable clinical finding in VKC patients. The study revealed conjunctival pigmentation in 28.7% of patients, while it was not present in 71.3% of patients. According to Rao et al, conjunctival pigmentation serves as both a specific and sensitive sign of VKC. Moreover, it is also observed in quiescent disease, making it a valuable aid in the diagnosis of VKC patients. (17) The primary strength of our study lies in its prospective design, offering valuable insights not commonly found in the majority of retrospective studies present in the literature. However, it is important to acknowledge that our study's limitations include its relatively small sample size. Effective patient and parental counselling is imperative, providing a comprehensive understanding of the disease's nature and the long-term necessity for medication. On the physician's end, diligent monitoring of intraocular pressure is crucial, enabling early detection and management of steroid-induced glaucoma.

CONCLUSION

In conclusion, this study provides valuable insights into the demographic and clinical characteristics of VKC patients. The findings contribute to our understanding of the age distribution, gender predominance, disease duration, associated allergic conditions, clinical manifestations, subtypes, disease severity, visual acuity, conjunctival pigmentation, and

complications in VKC. These findings are consistent with previous studies and help consolidate our knowledge about this challenging ocular condition. Further research and collaborative efforts are warranted to improve the diagnosis, management, and outcomes of VKC patients worldwide.

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LEGAL, RELIGIOUS AND INTERNATIONAL PERSPECTIVES ON EUTHANASIA: A NARRATIVE REVIEW

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ABSTRACT

This study delves into the contrasting viewpoints on euthanasia through the lens of Indian legal frameworks and Islamic jurisprudence. Euthanasia, an intricate ethical issue, is examined in its multifaceted dimensions, considering definitions, historical perspectives, international viewpoints, and ethical-legal standpoints. The Islamic perspective, unequivocally emphasizes the sanctity of life and the divine authority over its beginning and end. Islam adamantly prohibits both active and passive forms of euthanasia, aligning with the foundational belief that life's termination contradicts the divine will. Contrarily, the Indian legal landscape navigates a more intricate path, contemplating euthanasia through ethical and legislative lenses. While acknowledging the ethical complexities, Indian laws grapple with nuanced distinctions between passive and active euthanasia, seeking to balance individual autonomy and the preservation of life. Islamic jurisprudence staunchly prohibits any form of euthanasia except in specific circumstances like self-defense or capital punishment, aligning with the core principle of safeguarding life. Muslim jurists' opinions reinforce this stance, echoing the sanctity of life and the stringent prohibition against self-harm or intentional termination of life. Judicial trends reflect the divergence between these perspectives, showcasing the Indian legal system's attempts to address euthanasia within ethical and legal frameworks, while Islamic jurisprudence remains steadfast in its prohibition. This narrative review illuminates the stark contrast between the Indian legal approach, grappling with the complexities of autonomy and life preservation, and the unwavering stance of Islamic jurisprudence, rooted in the sanctity of life and divine decree. The global discourse on euthanasia encounters profound divergence in these perspectives, reflecting the intricate interplay between ethics, law, culture, and religious beliefs in end-of-life considerations.

Keywords: Euthanasia, Legal, Religion, International, Perspective

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INTRODUCTION

The discourse surrounding euthanasia, a deliberate act of ending one's life to relieve suffering, has permeated moral, legal, ethical, and religious realms, sparking contentious debates across the globe. The concept of euthanasia introduced by Sir Francis Bacon in the early 17th century revolves

around the notion of a compassionate demise, extending beyond natural death. Bacon coined the term 'euthanasia,' literally translating to a 'good death' or 'mercy killing.'¹ This practice involves ending life without causing unnecessary pain and suffering, aligning with the idea of living with

dignity. Euthanasia raises intricate questions about the right to a dignified death, the involvement of healthcare professionals in end-of-life choices, and the ethical and legal considerations surrounding assisted dying.

The global debate on euthanasia remains inconclusive, with no consensus among countries. Despite its prohibition in some nations, there are situations where individuals, facing dire circumstances and medical limitations, may seek release through death due to intense suffering. In such cases, euthanasia involves a purposeful act to terminate a person's life based on compassionate considerations with the patient's consent.

India grapples with the moral complexities of euthanasia within its legal system, navigating a fine line between compassion and preserving life. The judiciary, tasked with resolving ethical quandaries, faces challenges in this diverse nation with a rich cultural and religious tapestry. In contrast, Islamic law, deeply rooted in religious principles, emphasizes the sanctity of life and requires a delicate balance in end-of-life decisions. Islamic jurisprudence delves into the ethical dimensions of euthanasia, considering 'maqasid al-shari'ah' (objectives of Sharia) regarding the sanctity of life and compassionate considerations for the terminally ill.

Euthanasia, a debated issue in religion and law, involves the question of whether terminally ill patients should control the circumstances of their inevitable death. Advocates argue for compassion and individual autonomy, emphasizing the relief from unbearable suffering. Opponents express concerns about potential abuse and the devaluation of human life if euthanasia is allowed.

1. Euthanasia: Definition and Concept

Euthanasia, derived from the Greek roots "eu" (good) and "thanatos" (death), refers to a compassionate act aimed at relieving unbearable suffering through intentional life termination. Coined by Sir Francis Bacon, it involves the deliberate ending of life to alleviate intractable pain. The term has held this meaning since the 17th century and presently refers to methods used for a peaceful death. Often associated with sparing the very ill or elderly from further suffering, euthanasia is likened to a "kindly and pleasant sleep."²

According to the British House of Lords Select Committee on Medical Ethics, it is defined as, a deliberate intervention undertaken with the express intention of ending a life, to relieve intractable suffering.³

The practice of euthanasia raises ethical, legal, and moral considerations, particularly regarding the right to die with dignity and the protection of vulnerable individuals. It is crucial to understand the legal framework and conditions under which euthanasia is allowed. For instance, in the Netherlands, euthanasia is permitted under specific conditions, such as when a patient's suffering is unbearable with no prospect of improvement, and the patient's request for euthanasia is voluntary and well-considered. Physicians are not obliged to perform euthanasia, and strict due care criteria must be met to ensure compliance with the law.⁴

In Islam, physician-assisted suicide (PAS) and euthanasia are forbidden as life is deemed a sacred gift from God. Islamic doctrines emphasize the preservation of life, with the religion prohibiting any act that involves taking one's life, whether through patient consent (suicide) or physician execution (homicide). (Al-Anaam, 151& Al-Aaraf, 34)

1.1. Types of Euthanasia

There are several types of euthanasia. Some of them are:

- i. **Active euthanasia:** It involves the intentional administration of substances to bring about the patient's death. This may include the administration of lethal doses of medication, typically in response to a competent and voluntary request.
- ii. **Passive euthanasia:** It entails the withholding or withdrawal of life-sustaining treatment to allow a natural death to occur. This may involve discontinuing artificial ventilation, withdrawing medications, or withholding nutrition and hydration.
- iii. **Voluntary euthanasia:** It occurs when a competent individual, suffering from a terminal illness or unbearable pain, explicitly requests assistance in hastening their death. This form of euthanasia hinges on the principle of individual autonomy and the right to make decisions about one's own life.
- iv. **Non-voluntary euthanasia:** It involves situations where the patient's wishes regarding the termination of life are unknown or unclear. This often arises in cases of patients who are comatose or incapacitated, rendering them incapable of expressing their desires.
- v. **Assisted suicide or Physician-assisted suicide (PAS):** PAS means a doctor knowingly helps someone to end his life. When a person is likely experiencing persistent and unending suffering and may have also received a terminally ill

diagnosis, on his consent, his doctor will determine the most effective, painless method to end his life.

2. Historical and Cultural Perspectives

In ancient societies like Greece and Rome, euthanasia was accepted for those with incurable ailments or intolerable suffering. However, changing societal and religious values led to a re-evaluation of the moral aspects of intentionally ending life. The formal push for euthanasia legalization began in 1935 in England with C. Killick Millard founding the Voluntary Euthanasia Legalisation Society, later rebranded as the Euthanasia Society. Despite efforts, the proposed bill faced defeat in the House of Lords in 1936. Euthanasia was first legalized in the Netherlands and Belgium in the early 2000s, sparking ongoing debates on moral permissibility, patient autonomy, and the role of physicians in end-of-life care.⁵

Dr. Umar Hasan Kasole delves into the historical roots of euthanasia, tracing its acceptance from ancient Greece and Rome to certain Asian religious traditions like Buddhism, Shintoism, and Confucianism. The Middle Ages saw a shift in perception, with religious doctrines condemning euthanasia. This perspective endured into the modern era, influencing legal frameworks globally. The 20th century brought medical advancements, complicating the discourse around life prolongation and suffering relief.

The modern euthanasia discourse incorporates ethical considerations, individual rights, medical progress, and religious beliefs. Legal frameworks worldwide grapple with autonomy versus concerns about abuse, consent, and societal values. The history also reveals misuse during the Nazi regime's Aktion T4 program, targeting mentally

disabled individuals. This initiative, under the guise of "mercy death," led to the systematic extermination of vulnerable children, leaving a dark stain on euthanasia's history.⁶

Cultural attitudes toward euthanasia vary based on the emphasis on individual autonomy and religious influences. In some cultures, autonomy supports permissive views, while strong religious values often create moral barriers. Hinduism, for example, criticizes intentional self-inflicted death, known as "atmagatha," considering it rooted in ignorance and passion, with karmic consequences hindering spiritual progression. Legal perspectives on euthanasia differ globally, with some jurisdictions permitting it for the right to die with dignity, while others strictly prohibit assisted suicide or euthanasia. International views vary, with organizations like the World Health Organization advocating for comprehensive palliative care without endorsing euthanasia as a global norm.

3. International Perspectives

The ethical and legal dimensions of euthanasia have ignited intense debates on a global scale, prompting a nuanced exploration of the diverse international perspectives on this complex issue. Internationally, the legal stance on euthanasia varies significantly. Some jurisdictions, such as the Netherlands, Belgium, Luxembourg, and Canada, have legalized euthanasia under specific conditions, typically involving terminal illness, unbearable suffering, and the informed consent of the patient. In contrast, numerous countries, including many U.S. states, maintain a criminalization stance on assisted suicide. The dichotomy reflects deeply entrenched cultural, religious, and philosophical differences that underscore the challenges of establishing a universally accepted legal framework.

The international discourse on euthanasia centers on the right to life, as articulated in human rights instruments like the Universal Declaration of Human Rights. Divergent interpretations exist, with some advocating for the right to die with dignity, while others insist on the absolute preservation of life. Striking a balance between these perspectives poses an ongoing challenge for international legal bodies. Ethical considerations surrounding euthanasia, including the sanctity of life, autonomy, and the role of healthcare professionals, further complicate the issue. Proponents argue for regulated euthanasia as a compassionate response to terminal suffering, respecting individual autonomy. Opponents stress the inherent value of preserving life and express concerns about potential abuse or the erosion of the doctor-patient relationship. Regional attitudes vary, with Europe adopting more permissive legal frameworks compared to regions like Africa and Asia, where cultural and religious factors contribute to prevalent opposition. The evolving landscape, as seen in countries like Australia where certain states have recently legalized assisted dying, adds complexity to the international perspective.

In 2001, the Netherlands legalized euthanasia through the Termination of Life on Request and Assisted Suicide Act, a departure from previous restrictions. The 2002 Euthanasia Act expanded permissions to include active euthanasia and PAS, strictly based on the patient's explicit request. Criteria for euthanasia involve voluntary, well-considered requests from patients enduring unbearable and hopeless suffering. Patients must receive comprehensive information, explore alternatives, and seek another physician's opinion. The act of euthanasia must be conducted with

meticulous medical care, highlighting the emphasis on professionalism and thorough evaluation.

In Japan, euthanasia is legally defined as relieving acute physical pain for a terminally ill patient upon their sincere request. Types include Pure Euthanasia (lawful, doctor alleviates pain without hastening death), Indirect Euthanasia (lawful, pain-relieving drugs incidentally hasten death), Active Euthanasia (debatable legality, direct removal of physical means), Passive Euthanasia (generally accepted, refraining from life-prolonging measures), and Physician-Assisted Suicide (unlawful). Passive euthanasia criteria include terminal condition, incurable illness, voluntary patient decision to halt treatment, and cessation of all medical interventions.

Luxembourg became the third country to decriminalize euthanasia on March 16, 2009. The law permits terminally ill individuals to choose to end their lives, subject to approval from two doctors and a panel of specialists. This careful process aims to prevent misuse and prioritizes the well-being of the patient.

Canada witnessed significant changes after the Supreme Court's ruling in *Cartar v. Canada*, leading to shifts in euthanasia policies⁷. In China and Hong Kong, euthanasia remains illegal due to conflicting moral principles, equating it with murder under Chinese law. In the United Kingdom, despite the Human Rights Act of 1998, euthanasia is illegal, and assisting suicide is a statutory offense. The House of Lords, in *R (on the application of Pretty) vs. Director of Public Prosecutions*, maintained that existing laws prevail, emphasizing the UK's stance against legalizing assisted suicide.⁸

In Germany, the legal distinction between active and passive euthanasia allows for active euthanasia

while permitting the cessation of life-prolonging measures in passive euthanasia without criminal consequences. This nuanced approach prioritizes patient autonomy.

In contrast, the United States criminalizes active euthanasia but permits physician-assisted suicide in specific states like Oregon and Washington. These states strictly regulate the process, allowing only self-assisted dying. In the US, a doctor's withdrawal of life support aligns with the patient's explicit request, emphasizing a delicate balance between patient autonomy and legal boundaries in end-of-life care.

4. Euthanasia In the Indian Legal Framework

Euthanasia is a criminal offense in India under Section 309 of the Indian Penal Code, which addresses suicide attempts, and Section 306, which concerns abetting suicide. Withdrawal of life support is permitted only for brain-dead individuals, with guidance or family consent. The Supreme Court clarifies that the constitutional right to life (Article 21 of the Indian Constitution) doesn't include the right to choose death, emphasizing it as a safeguard for life and personal freedom. Despite the 2006 Law Commission's bill on euthanasia, the health ministry has not enacted any related legislation.

The legal journey of euthanasia in India traces its roots to the landmark case of Aruna Shanbaug, in 2011, when the Supreme Court of India while denying the plea for euthanasia, recognized the need for a comprehensive legal framework.⁹ Subsequently, in 2018, the Supreme Court, in the case of *Common Cause v. Union of India*, decriminalized passive euthanasia, endorsing the right to die with dignity.⁹ The court articulated that individuals have the autonomy to refuse medical

treatment and laid down guidelines to govern the process of passive euthanasia, affirming the principle that life and death are inextricably linked to individual dignity.

In response to judicial directives, the Indian Parliament enacted the "The Human Rights Decennial Bill" in 2020, which legalized passive euthanasia and established a legal framework for living wills. The legislation aims to provide individuals with the right to make advance directives, expressing their desire to refuse medical treatment in case they become incapacitated. This legislative intervention reflects a progressive stance, acknowledging the importance of individual autonomy in end-of-life decisions.

The inclusion of living wills as part of the legal framework is a notable development in Indian euthanasia law. This instrument allows individuals to express their wishes regarding medical treatment in advance, ensuring that their autonomy is respected even when they are no longer able to communicate. The legal recognition of advance directives provides individuals with a mechanism to maintain control over their medical decisions, reinforcing the principle of dignity in death.

5. Euthanasia In Islamic Jurisprudence

As the global discourse on euthanasia evolves, Islamic jurisprudence stands as a rich tapestry of thought that navigates the complexities of life, death, and human suffering. Islamic law, derived from the Quran and Hadith, places great emphasis on the preservation of life and the belief that human existence is divinely ordained. The concept of euthanasia conflicts with the Islamic principle of respecting the sanctity of life, as it involves intentionally terminating life, which is deemed forbidden in Islamic teachings. Islamic teachings

strictly prohibit suicide, highlighting that those who take their own lives will face severe consequences in the afterlife. Hadiths warn that those who commit suicide will face eternal torment related to how they ended their lives.

The Quran emphasizes the sanctity of life and prohibits actions leading to self-destruction, citing verses such as "do not kill yourselves" (Surah Nisa: 29) and "do not cast yourselves into destruction by your own hands" (Surat Al-Baqarah: 195). It equates the unjust killing of a single soul to the killing of all humanity (Al-Ma'idah: 32) and stresses that no soul should be unlawfully taken except with justice (Al-Baqara 195). The severe consequences for intentionally taking a believer's life are also underscored (Al-Anaam: 151).

Additionally, the Quran prohibits both active and passive euthanasia, as seen in verses like "Do not kill your children for the sake of poverty" (Al-Anaam: 151), emphasizing that sustenance comes from Allah and one should not take a life due to financial difficulties. The text reaffirms the prohibition of ending life without just cause, including both deliberate measures and actions that might lead to the termination of life.

The Quran also stresses accountability for the unjust killing of a human being, highlighting the obligation for retribution for the slain (Al-Baqarah: 178). It emphasizes the fixed term for each individual's life, stating that one cannot hasten or delay their appointed time of death (Al-Araf: 34, Surah Momin: 67). Allah is the giver and taker of life (Surah Al-Hadid: 2, Al-Dukhan: 8), and the Quran states that He has created life and death to test humanity (Al-Mulk: 1-2). Furthermore, it mentions that believers have offered their lives to Allah and will be rewarded in the Hereafter (Taubah: 111).

These verses collectively emphasize the sanctity of life, the prohibition of unjustly taking a life, and the understanding that life and death are in the hands of Allah alone. They inherently reject any form of euthanasia, active or passive, highlighting that life and death are aspects determined solely by divine will, and humans should not interfere in this natural process.

Hadiths from the Prophet Muhammad (peace be upon him) reinforce the value of life and the forbiddance of self-harm. Narrations discourage wishing for death due to pain or suffering, as these afflictions might serve as a means of expiation or elevation of one's status in the Hereafter. The Hadiths emphasize that no one should wish for death due to pain or suffering, regardless of whether they are experiencing good or evil deeds. The Prophet teaches that enduring pain might elevate a good person's status and could potentially lead to forgiveness for someone wicked. Moreover, the Prophet explicitly condemned various methods of ending one's life, such as using sharp instruments or poison, warning that how one takes their life will be their eternal torment in the Hereafter.

The Hadith also stresses the sanctity of a Muslim's life, indicating that shedding the blood of a believer is impermissible except in specific circumstances such as in cases of capital punishment, self-defense, or in matters of adultery, abandoning one's religion, or murder.

The sanctity of life, as emphasized in Islamic teachings, serves as a foundational pillar when contemplating end-of-life decisions. Islam prohibits any form of euthanasia, including both active and passive, as well as any form of assisted suicide. In Islamic jurisprudence, the sanctity of life is paramount, and the taking of life is permissible only

in specific circumstances such as in cases of self-defense, capital punishment for murder, or in the defense of the community. The overarching principle remains the protection and preservation of life.

The intersection of Islamic jurisprudence and contemporary ethical debates on euthanasia reflects the sanctity of life as a fundamental principle in Islam. Muslim jurists generally view deliberately ceasing medical treatment to hasten death as abominable and strictly prohibited (haram), emphasizing that only Allah has the authority to give and take life. They assert that preserving life takes precedence over alleviating suffering, condemning both active and passive euthanasia. Sharia law prohibits the deliberate abandonment of medical treatment, stressing the obligation to pursue treatment fully. Islamic teachings advocate for doctors' accountability and good intentions, emphasizing that harming or ending life unjustly is a grave sin. While some scholars argue for euthanasia in cases of unbearable suffering, the broader Islamic ethos prioritizes preserving life and providing compassionate care to ease suffering. Legalizing euthanasia would contradict Islamic principles, undermining the sanctity of life and societal values. Overall, Islamic ethics emphasize the preservation of life and oppose actions leading to self-harm or the unjust taking of life.¹⁰

6. Judicial Trends

The jurisprudential discourse surrounding euthanasia, or the intentional termination of life to relieve suffering, has become a contentious arena, demanding nuanced legal considerations and ethical reflections.

Internationally, the right to life is a foundational human right, and discussions on euthanasia navigate

the delicate balance between preserving life and respecting an individual's autonomy. The European Court of Human Rights (ECHR) has played a pivotal role in shaping these discussions, emphasizing the importance of an individual's right to choose the circumstances of their death while safeguarding against abuse. Notably, the landmark case of *Pretty v. the United Kingdom* underscored the significance of respecting an individual's autonomy in end-of-life decisions.¹¹

In a Canadian case, *Gloria Taylor v. Canada*, the British Columbia Supreme Court struck down the criminal laws prohibiting physician-assisted suicide. The court found that the laws violated the Canadian Charter of Rights and Freedoms by depriving individuals suffering from grievous and irremediable medical conditions of the right to control their death.¹²

In India, the legal stance on euthanasia has experienced a significant transformation. The case of *Airedale N.H.S. Trust v. Bland* emphasized that mercy killing is not sanctioned under common law and requires legislative approval.¹³ The case involved the withdrawal of life-sustaining measures for a doctor facing imminent death. Anthony Bland, a Liverpool Football Club supporter, suffered severe injuries at Hillsborough Ground, resulting in a disrupted blood supply to his brain and irreversible brain damage. The House of Lords clarified that euthanasia lacks legality under common law and must be authorized through legislation. It may be permitted only in cases where the suffering from assisted suicide is minimal compared to the distress that euthanasia seeks to alleviate. The state is urged to uphold the 'sanctity of life' principle.

In the pivotal *Gian Kaur v. State of Punjab* case, the Supreme Court of India elucidated the legal stance on euthanasia.¹⁴ The court asserted that the constitutional "right to life" as per Article 21 does not encompass the right to choose death. This ruling confirmed the validity of Section 309 in the Indian Penal Code, which criminalizes suicide attempts, and underscored the state's interest in safeguarding life. The court emphasized the distinction between natural end-of-life processes and unnatural deaths, emphasizing the sanctity of life. The five-judge constitutional bench upheld the constitutionality of Sections 306 and 309 of the Indian Penal Code, 1860. The apex court categorically stated that both euthanasia and assisted suicide lack legal standing in India, emphasizing that any endorsement of euthanasia should only occur through legislative means.

In 2006, the Law Commission of India presented the 196th Report addressing terminally ill patients. The report advocated for the legalization of 'passive euthanasia' under stringent controls. It explicitly stated that both euthanasia and physician-assisted suicide would remain illegal. The focus of the report was on safeguarding patients facing a permanent vegetative state with no chance of recovery. In such situations, the patient, through voluntary oral or written requests, could seek the removal of life support, expediting their death with specific safeguards in place. The attending doctors were obligated to fully inform the patient about their condition and prospects. The report emphasized that doctors should not forcefully maintain life support against the patient's will. According to the report, the patient's directive in this context was binding on the doctor, offering legal protection under Section 306 IPC.

Additionally, in cases involving an incompetent patient, the next friend was required to obtain a mandatory clearance from the High Court to facilitate the withdrawal of life support.¹⁵

The Supreme Court addressed the comprehensive discussion on euthanasia in the landmark case of *Aruna Ramchandra Shanbaug v. Union of India*.¹⁶ Despite rejecting the mentioned report, the court legalized passive euthanasia without specific legislation, following the provided guidelines. However, the legalization of active euthanasia was expressly denied under existing statutes, pending the enactment of a specific law by Parliament. Regarding active euthanasia, the court affirmed its classification as a criminal offense, punishable under Section 302 or at least 304 IPC when committed by an individual, and under Section 306 when carried out by a doctor as Physician-Assisted Suicide (PAS). The court maintained that active euthanasia remains illegal unless the legislature introduces a law for its legalization. The court expressed concerns about potential misuse, labeling it as 'constitutional cannibalism' and 'judicial murder.' The decision to terminate life support can be made by parents, spouses, close relatives, or, in their absence, by a person or group acting as a next friend. Additionally, doctors attending the patient can make such decisions, ensuring that they are made in good faith and in the best interest of the patient.

The 2012 Law Commission Report, submitted in August, advocated for the legalization of passive euthanasia, inspired by the Aruna Shanbaug case. In this case, the Court established guidelines for passive euthanasia but rejected the complete decriminalization of active euthanasia. The judgment incorporated some principles from the

196th Report, prompting a reassessment of legalizing passive euthanasia and a revision of the proposed Bill for legislative presentation. The current Report, in alignment with the Court's stance, proposes the necessity of a law based on the guidelines outlined in the Aruna Shanbaug case. However, it emphasizes that active euthanasia and Physician-Assisted Suicide (PAS) should remain illegal. Active euthanasia is deemed punishable under Section 300 (voluntary) and Section 302 (involuntary) of the Penal Code, while PAS is opposed to Section 306 of the Code.

The court addressed the issue of passive euthanasia and the right to die with dignity. While the court did not grant permission for euthanasia in the specific case, it acknowledged the need for a comprehensive legal framework and guidelines to address end-of-life decisions.

In the case of *Anamika Mishra v. State of U.P.* (2018), the Allahabad High Court dealt with the issue of withdrawal of life support for a patient in a persistent vegetative state.¹⁷ The court, while recognizing the right to life with dignity, emphasized the importance of following established legal procedures and obtaining court approval for withdrawing life support.

A landmark progression in Indian euthanasia jurisprudence occurred with the *Common Cause case*. The Supreme Court, in its judgment, expanded on the Aruna Shanbaug decision and recognized the legality of passive euthanasia and the concept of a "living will." The court affirmed the right to a dignified death as intrinsic to the right to life. The judgment outlined procedural safeguards, including the necessity of a medical board's certification, to ensure the protection of vulnerable individuals.

CONCLUSION

Life is the most valuable possession, a trust in Islam, and a focus on global religions and laws. Suicide, regardless of means, is strictly forbidden with severe consequences in the afterlife. Islam prohibits playing with one's life or others and even the desire for death. Life isn't personal property; disposing of it is forbidden. Suicide harms others and violates rights. Consent to be killed isn't an exception, requiring compensation instead. Abandoning treatment, though optional, is generally unacceptable. Euthanasia advocates argue for the right to choose for relief from suffering. Ancient religions allowed self-dying, but Abrahamic religions deem it invalid. Euthanasia is legal in some places but prohibited globally. India lacks specific legislation, with the Apex Court allowing passive euthanasia under specific conditions.

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