VITRIOLAGE IN INDIA: ANALYSIS BY A BURN SURGEON

LE «VITRIOLAGE» EN INDE: ANALYSE D'UN CHIRURGIEN BRÛLOLOGUE

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SUMMARY. Acid throwing (vitriolage) is a form of violent assault. It is described as an act of throwing acid or corrosives on the body of a person with the intention of injuring or disfiguring them. It is a crime like no other and represents the amalgamation of social evils like patriarchy, gender bias, disdain for the laws of the land, and individual deficiencies like jealousy, anger and sexism. Its incidence has increased over the years and it is soundly entrenched in our society. On the brighter side, surgical care has improved, laws have evolved and, most importantly, society is now aware and is playing an active role against this sacrilege. This study intends to analyze the various aspects of vitriolage in the Indian context, i.e. the extent of the problem, how it affects more than one life, and how the laws have evolved to protect the victims. Secondly, the challenges encountered, from the point of view of a health care worker, specifically a Burns/Reconstructive surgeon, are addressed. It is an attempt to bring on board issues that are medical, administrative or legal and are intricately connected with care and support of victims and survivors of vitriolage. The specific questions discussed in this study are related to the dilemmas faced by the medical community/healthcare institutions while dealing with patients of vitriolage and how the laws have evolved over a period of time.

Keywords: acid attacks, vitriolage survivors, acid attack laws, management of acid injuries

RÉSUMÉ. *La projection d'acide (« vitriolage ») est une forme d'agression violente. Il décrit la projection volontaire d'acide ou d'autre agent corrosif sur une tierce personne dans l'intention de la blesser ou la défigurer. Ce crime particulier concentre plusieurs travers sociétaux comme le patriarcat, la différence de genre, le refus des lois fédérales ainsi que des comportements individuels (jalousie, colère, sexisme). Ce type de violence, profondément ancré dans notre société, a vu son incidence augmenter avec les années. Cependant, la prise en charge chirurgicale s'est améliorée, les lois ont évolué et, plus important, la société s'implique dans la dénonciation et la lutte contre cette abomination. Cette étude analyse le vitriolage en Inde sous ses différents aspects : étendue, conséquence sur la vie de plusieurs personnes, évolution législative dans le but de protection des victimes. Nous décrivons les problèmes à résoudre par les soignants, en particulier les chirurgiens plasticiens. Le tout dans le but de mettre en avant l'intrication systémique (santé, légale) et technique (prise en charge) des victimes de vitriolage. Spécifiquement, nous sommes devant la question de l'évolution des soins et des lois face au phénomène et aux patients.*

Mots-clés : *agression, acide, vitriolage, survivants, loi, traitement*

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Introduction

Acid throwing or 'vitriolage' is a form of violent assault.[1,2] It is described as an act of throwing acid or corrosives on the body of a person with the intention of injuring or disfiguring them out of jealousy or revenge, resulting in burning and dissolution of the victim's skin, connective tissue and even bones.[3]

Historically speaking, acid attacks are not new. Their origin dates back to Victorian England of the 1700s. It was a time of industrial revolution, and acid was easily available to the public. Thousands of attacks of 'vitriol hurling' were reported during this period. In 1763, the first vitriol factory was established in Twickenham, England. In 1834, one of the first recorded cases of acid attack was noted in Scotland. As time went on, the frequency of attacks declined in Europe but started to rise in Asia. South Asia, Latin America and Africa are the present hotbeds of vitriolage in the World. With Bangladesh, Cambodia and Pakistan as epicentres, India also does not lag behind in number of cases.

We do not have a Burn Registry, and in the absence of specific laws, data until 2013 was unreliable. After 2013, when laws specific to acid attacks started to be enacted, some data started trickling through. It is estimated that there were 174 cases of acid attack in India in the year 2000 (226th Law Commission Report). In Laxmi vs. Union of India & Ors on 10 April, 2015 (Supreme Court of India), it is noted that 309 cases occurred in 2014. We believe this to be an underestimation, and this is an issue (non-availability of a burn registry in India) that has been raised in this document.

It is a crime like no other, and represents the amalgamation of social evils like patriarchy, gender bias, disdain for the laws of the land, and individual deficiencies like jealousy, anger, sexism etc. The bitter truth is that its incidence has increased[4] over the years and it is soundly entrenched in our society. On the brighter side, surgical care has improved, laws have evolved, and, most importantly, society is now aware and is playing an active role against this sacrilege. Although all members of a sane and mature society have single-minded disdain for this act, it requires a seamless fusion of actions of all stakeholders - health care givers, law enforcing agencies, judiciary and the civil society - to effectively counter it.

This study intends to analyze the various aspects of vitriolage in an Indian context, i.e. the extent of the problem, how it affects more than one life, and how the laws have evolved to protect the victims. Secondly, the challenges encountered, from the point of view of a health care worker, specifically a burns/reconstructive surgeon, are addressed. It is an attempt to bring on board issues that are medical, administrative or legal and are intricately connected with care and support of victims and survivors of vitriolage. The discussion, with the help of present-day medical practice norms, laws and judgments, also tries to clear up certain doubts within the medical community as well as raise certain questions for all of us to ponder and act upon.

The specific questions discussed in this study are as follows:

- What are the dilemmas faced by the medical community/healthcare institutions while dealing with patients of vitriolage? Are standard operating procedures (SOPS) crystal clear?
- How have the laws evolved over a period of time?

Material and methods

This study is a doctrinal document. The sources include both medical and legal books, journals, articles, online data like landmark judgments, bare acts and statutes.

Type of documents and sources of information

Legal perspectives, older laws and their insufficiency. Initially, the Indian Penal Code (IPC) under sections 320, 322, 325 and 326 provided relief to the victims.[1] It was observed that the perpetuators were charged for causing hurt or grievous hurt. As these are non-specific sections, and were not directed towards acid attacks per se, they were insufficient to provide justice and deterrence against this gruesome act.

Under existing laws, there was no clarity whether a person should be charged with causing "hurt" (IPC Section 324) or "grievous hurt" (IPC Section 326). A charge for "grievous hurt" carries with it a sentence of life imprisonment, but a charge of "hurt" carries only a maximum penalty of three years. Sec-

tion 320 defines "grievous hurt" as emasculation of the victim's reproductive and sexual organs, permanent privation of the hearing of either ear, privation of any member or joint, the destruction or permanent impairing of any member or joint, permanent disfiguration of the head or face, fracture or dislocation of a bone or a tooth, and any hurt that endangers life or which causes the sufferer to be in severe bodily pain over the space of 20 days, or unable to follow [her or his] ordinary pursuits.

The definition of "grievous hurt" does not account for the specific circumstances of acid attacks. Therefore, it was imperative that the laws, being insufficient, should be amended in the course of time.

226th Law Commission - The new dawn. In July 2009, the 226th Law Commission Report[5] followed by the Justice Verma Committee[6] report dealt specifically with this problem.

The report stated: "Firstly, the definition of grievous hurt is not broad enough to cover the various kinds of injuries which are inflicted during acid attacks. Secondly, the section does not cover the act of administering acid. Thirdly, the section gives a wide discretion to the courts as far as punishment is concerned. The cases of acid attacks in India show that normally inadequate punishment is awarded in these cases. Fourthly, the section in the IPC does not punish the intentional act of throwing of acid if no injuries occur. Lastly, the section also does not specify who the fine should be awarded to". Continuing, the report stated: "Though acid attack is a crime which can be committed against any man or woman, it has a specific gender dimension in India. Most of the reported acid attacks have been committed against women, particularly young women, for spurning suitors, for rejecting a proposal of marriage, for denying a dowry etc. The attacker cannot bear the fact that he has been rejected, and seeks to destroy the body of the woman who has dared to stand up to him".

Modifications in the Indian Penal Code (IPC). A new section - 326A - was proposed to be added to the Indian Penal Code. The proposed Section 326A read as follows: 326 A (i) Hurt by acid attack - Whoever burns or maims or disfigures or disables any part or parts of the body of a person or causes grievous hurt by throwing acid on or administering acid to that person, with the intention of causing or with the knowledge that he is likely to cause such injury or hurt, shall be punishable with imprisonment of either description which shall not be less than 10 years but which may extend to life, and with fine which may extend to Rs. 10 Lakhs.

Modifications in the Indian Evidence Act. The Commission further proposed changes in the Indian Evidence Act under section 114B titled: "Presumption as to acid attack", where if a person has thrown or administered acid on another person, the court shall presume that such an act has been done with the intention of causing such harm, and with the knowledge that such an act is likely to cause such grievous hurt or injury as mentioned in section 326A of the IPC.

Vitriolage - medical perspective

An important cog in the wheel is the health care provider, notably the plastic surgeon/burn surgeon who heads the multidisciplinary team that takes care of the patient. His/her insight is, I believe, very important whenever the victims are being discussed.

Introduction of the team. Corrosive burns are best dealt with by a multi-disciplinary team of doctors and health care providers. This team comprises of critical care specialists, ophthalmologists, psychiatrists, physiotherapist and nursing team, and is led by a plastic reconstructive surgeon.

Initial treatment. Following initial injury, the impetus is on saving the life of the patient and negating any ongoing damage by the residual acid in the clothing, eyes, mouth etc. Therefore, resuscitation of the patient, copious irrigation to wash out the acid/alkali,[7,8] and prompt care for vital and sensitive organs like the eyes are of utmost priority.

Mental turmoil of the patient. Unexpectedness of the event and the fact that, in the majority of cases, the face is targeted, leading to temporary or permanent blindness or inability to speak properly, is trauma that has both physical and psychological aspects. This point is vital, as it means that the treating team is not only good technically, but well sensitized as regards patient mental turmoil.

Groundwork of management. Once the patient is stabilized and immediate threats are taken care of, the next important step is to mobilize the multidis-

ciplinary team. It needs identification of members and intimation so that care starts promptly. Another vital step at this juncture is the preparation of a Medico Legal Report (MLR). It is again one of the most critical steps which, if properly made following guidelines, will go a long way in ensuring justice. An improperly prepared MLR with insufficient information is a great disservice to the patient who now needs our support in every possible manner.

The beginning of the battle. This is followed by a phase that sets the tone for future events:

- The patient, now stable and out of danger, has come to terms with their loss and has to be physically and mentally prepared for treatment,[9] lasting years, as well as a legal battle. They now have to accept their new 'self'.
- The doctors/plastic reconstructive surgeons also now have a better understanding of the patient's loss, and make a plan to reconstruct one by one each organ lost or disfigured. These surgeries require tremendous skills, experience and accurate planning, but still desired results are not readily obtained.
- The law-enforcing agencies have also by now started their investigation process. It is the quality of this investigation which will help in delivering justice.

Loss becomes evident. There is no immediate loss of organs like nose or ears. As time elapses, slowly the denatured parts start to show demarcation and it becomes evident what tissue is going to be lost. The tissue gets infected and separates from the body, leaving raw areas (areas of unhealed skin), as well as loss of organs like eyes/nose or ears. Further attempts by the body to heal distort the anatomy and cause what are known as contractures - pulling away of lips or eyelids etc. The combination of these two processes leads to formation of final disfigurement.

As already discussed, in this initial phase the attempt is to save vital organs like eyes. So, subsequent procedures are priority-surgeries directed towards eyelids, so that eyes can be closed and cornea is protected; lips, so that the patient can eat or close their mouth; neck, so that they can see straight, or coverage of raw wounds with skin grafts.

Unending cycle of surgeries. Following this, the patient is reassessed and a plan is made to start reconstruction of nose/ears/lips etc. Several methods like skin grafting, local/regional flaps, micro vascular flaps, tissue expanders etc. are used for this. Each surgery takes time and planning. This, in reality, means not weeks or months, but years. Even after that, depending upon the severity of the assault, normal pre morbid facial features are seldom achieved and the patient has to see and accept a 'new' self after each surgery. The process continues and session after session of lasers, minor surgeries etc. continue. There is no end point of completion of treatment. This issue is a cause for one of the greatest moral and legal dilemmas for the surgeons.

Surgeon's dilemma. At what point do we tell the patient to stop going for further procedures? Or should this ever be told, as every time they go under the knife, there is a possibility of improvement. So, it is their right to go ahead as long as they want.

It is clear that the financial burden should not fall on the patient. But who *should* take care of it? State, hospitals (government or private) or the perpetuators? Although this question has come up several times during various cases, there is still little clarity, especially in the medical community.

Discussion

The fundamental rights offered to us by our constitution reflect the civility and maturity of any society. The bitter truth is that no place can be free from crime. Having said that, it is up to the nation, its government, its institutions and civil society to continuously adapt, bend, change and come up with solutions to counter crime. Hatred, jealousy, addiction to power and money etc. are innate to humans, therefore it is unlikely that crime will ever end, but the human mind also has other inherent qualities - those of perseverance, justice and equality.

Vitriolage – a crime like no other

More than any other crime, vitriolage brings out the depths to which the human mind can descend, and it also uncovers the strength it has - to recover, rebuild and move on.

The support structure

All participants of the society, including the law-enforcing agencies, health care workers, judiciary and activists, have always come forward and played a role to support people who have been subjected to crime. They form the support structure for vitriolage survivors, and so strengthening this support system and making their efforts additive and seamless is the need of the hour.

Obstacles on the road to recovery

Having described vitriolage from the perspective of a burns surgeon, and having discussed the present legal framework and its evolution, we want to address the questions raised initially:

- Are we doing enough to make the road any smoother for the victims?
- Are our systems in place right, from the scene of the crime to the treating hospital, and, finally, is the courtroom waterproof?

During this discussion, we have also come up with certain suggestions.

Emergency care - only area with no doubt

If we consider the emergent care of the victims, as soon as the patient is taken to the first hospital, be it private or government, the system should automatically switch on. As directed by the Honorable Supreme Court multiple times [Parman and Katara vs. Union of India; Paschim Banga Khet Mazdoor Samiti & Ors vs. State of West Bengal] (*Table I*), life is considered most important, and thus conservation of the same remains the first priority. The laws are crystal clear in this regard and there is no ambiguity. The first doctor who sees the victim has to offer first aid treatment to the best of his/her abilities.

Training - the sore point

It is practically impossible to have a plastic reconstructive/burns surgeon at the first hospital most of the times, which would be an ideal situation. It is considered that medical officers who man the emergency rooms of the peripheral hospitals should be well versed to take care of this patient. Intervention at this level is vital and therefore proper training, if imparted, would do a great service to the patient. This may be made possible locally by the Faculty of the nearest medical college. Interesting to note is the National Program for Prevention of Burn Injuries (NPPBI) which is in its pilot stage. In regions where this program is running, it is easier, as infrastructure to manage burn as well as manpower is already in place.

Burn registry - why don't we have one?

Going further, it is to be noted that there is no formal burn registry in our country and so data regarding the actual number of victims is unavailable. This situation has multiple implications, namely administrative problems like difficulty in allocating

Table I - Judgements

Srl.no.	Case Name	Court of Judgement	Case Number
1.	**Ranjana Devi** vs. **Union of India** & **others** on 21st August, 2017	Punjab and Haryana High Court	Civil Writ Petition (CWP) No. 15430
2.	**Laxmi** vs. **Union of India & Ors** on 10th April, 2015	Supreme Court of India	CWP No. 129 of 2006
3.	**Parivartan Kendra & Anr** vs. **Union Of India & Ors** on 7th December, 2015	Supreme Court of India	CWP No. 867 of 2013
4.	**State Of Karnataka by Jalahalli** vs. **Joseph Rodrigues** S/O V.Z. on 22nd August, 2006	Karnataka High Court	Criminal Appeal (CA) No. 1065/2004
5.	**The State Of Maharashtra** vs. **Ankur Narayanlal Panwar** on 12th June, 2019	Bombay High Court	CA No. 139/2017
6.	**Sabana Khatun** vs. **The State of West Bengal and Ors** on 28th February, 2014	Calcutta High Court	Writ Petition No. 34704 of 2013
7.	**Raja** vs. **State of Haryana** on 28th May, 2019	High Court of Punjab and Haryana	CRA-D-484-DB of 2012
8.	**Manoj Kumar** vs. **State of U.P**. on 23rd May, 2017	Allahabad High Court	CA No. 4721 of 2010
9.	**State of Uttarakhand** vs. **Ajam** on 12th June, 2017	Uttaranchal High Court	Government Appeal No. 12 of 2011
10.	**Anju** vs. **State of Haryana and Ors** on 4th April, 2016	High Court of Punjab and Haryana	CWP No. 21842 of 2015
11.	**Pt. Parman and Katara** vs. **Union of India and Ors** on 28th August, 1989	Supreme Court of India	1989AIR2039, SCR(3)997
12.	**Paschim Banga Khet Mazdoor Samity & Ors** vs**. State of West Bengal** on 6th May, 1996	Supreme Court of India	1996SCC(4)37, JT1996(6)43

funds/manpower to help these patients, providing infrastructure in hospitals to specially manage these patients etc.

Moving forward - single nodal point for all issues

Being a special situation, it can be made notifiable to the Chief Medical Officer (CMO), thus initiating a cascade of events, starting from referral to a designated hospital, release of funds or medicines for treatment, tracking the status of the patient and ensuring that they get the management they deserve and are not lost to follow up. They should not have to run from pillar to post for treatment, admission, legal assistance etc.

Treatment - who should do it and who should finance it

Now, we come to another issue which is quite confusing. In a ruling, it was held that the treatment including reconstructive surgeries should be done free of cost, even by private hospitals. This ruling, as far as emergent care is concerned, is clear and without any confusion, but when multiple reconstructive surgeries are to be done, there is very little clarity.

The questions that arise include how individual plastic surgeons having a small setup or freelance practice can manage multiple surgeries. Even if done free of cost by the doctor, the consumables run into lakhs. Similarly, even bigger hospitals that can absorb more than private individual doctors cannot indefinitely provide care, for pure financial reasons. These issues remain in a gray zone, unresolved in the absence of crystal-clear guidelines.

NPPBI - is it the missing link?

We have around 300 cases of vitriolage in one year, and these can be taken in by designated hospitals, be it government or private. Furthermore, it should be our effort to provide the best care in the hands of the most experienced surgeons. This is all possible if a single step of maintaining a registry is done. If the National Programme for the Prevention of Burn Injuries (NPPBI) sees the light of day, again the logistic aspect will be handled comfortably. Therefore, identification of institutions/doctors (both private/government) could greatly negate this confusion and help the patients.

Control over sale of corrosives

Continuing with the discussion, judgments by the honorable Supreme Court and resultant guidelines from the government have led to better regulation of the sale of corrosives in the market.

Some suggestions

This discussion, which has been restricted to only the legal and administrative matters involving doctors/hospitals, brings forward the following points:

- In the absence of a formal Burn Registry, all our efforts are at best ad hoc.
- A Command Centre to regulate or manage various stages of treatment, and help and train doctors in peripheral health facilities for emergency management and writing proper MLC Medico Legal Reports is required.
- Such a Centre can track the patient and take their medical treatment, as well as quest for justice, to a logical conclusion.
- More guidelines, especially regarding the treatment part and finances, are needed. In this regard, associations like the Association of Plastic Surgeons of India (APSI) or the National Association of Burns in India (NABI) can come forward and participate.
- Treating doctors should be well aware of the process of change of laws and various government schemes/facilities for acid attack survivors so that they may also at some point participate in it in order to guide the patients correctly.

Conclusion

Vitriolage is a crime that has its roots deep in our social fabric. It denotes patriarchy, gender bias and a sense of invincibility, apart from the criminal mindset of the perpetuators. Its effects are devastating - physically, emotionally, mentally, socially and economically, and they stay with the victim throughout their lifetime. A society that is just a bystander only emboldens the criminals. In fact, whatever efforts we make are never going to be enough. Still, it is our duty to do our best - doctors to provide care and treatment as well as participate in the legal

process, law enforcing agencies to do timely accurate investigations, support groups/NGOs to rehabilitate the survivors, and judiciary to provide timely justice.

Limitations of the study

No official registry of vitriolage victims or status of treatment is available. Therefore, real-time data is not available.

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