CHAPTER 5

PATIENT'S RIGHT TO AUTONOMY

5.1. INTRODUCTION

The imperative of individual autonomy in healthcare is well described by Judge LJ in the case of *St. George's Healthcare NHS Trust* v *S*; *R* v *Collins, ex S*[1]:

> When human life is at stake the pressure to provide an affirmative answer authorizing unwanted medical intervention is very powerful. Nevertheless, the autonomy of each individual requires continuing protection even, perhaps particularly, when the motive for interfering with it is readily understandable, and indeed to many would appear commendable…

Patients cannot be required to accept treatment that they do not want, no matter how painless, beneficial and risk-free the treatment may be and no matter how dire the consequences of refusal of treatment.[2] This is because of the reason of bodily inviolability.[3] To breach this, even in the most well meaning way, is an affront to notion of our bodily integrity.[4]This proposition is recognized both as an ethical principle and a legal rule, and is founded, ultimately on the principle of respect for patient's autonomy, or expressed in more compelling terms, on the patient's right to self-determination.[5] The right to have control over one's body and refuse unwanted touching was recognized by the US Supreme Court in *Union*

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1 [1998] 3 All ER 673,688. Despite understanding the potential risks S wanted her baby to be born naturally. However, S was forced to undergo Caesarean section on advice of doctor. The court held that an adult of sound mind was entitled to refuse medical treatment, even when his or her own life depended on receiving such treatment. The court went on to state that in the case of a pregnant woman, that right was not diminished merely because her decision to exercise it might appear morally repugnant.

2 See, *Sidway* v *Bethlem Royal Hospital* [1985] 1 All ER 643,649; *Re T (Adult: Refusal of Treatment)* [1992] 4 All ER 649; *Airdale NHS Trust* v *Bland* [1993] 1 All ER 821.One must remember that the patient must be competent, i.e., have sufficient mental capacity to make a treatment decision. It is the duty of the doctor to decide whether the concerned patient is competent enough to take the decision. Suppose, if he lacks competence the doctor's are entitled to treat the patient as per 'best interest' principle.

3 See, *Re F (Mental Patient: Sterlisation)* [1989] 2 All ER 545, 563; *Re T (Adult: Refusal of Treatment)* [1992] 4 All ER 649.

4 Marc Stauch, Kay Wheat, John Tingle, *Sourcebook on Medical Law*, 2nd edn, Cavendish Publishing Limited, London (2002),p.103.

5 See, *Airdale NHS Trust* v *Bland* [1993] 1 All ER 821, 866.per Lord Goff. see also, DoH guidance in *Reference Guide to Consent for Examination or Treatment*, UK (2001), viewed 8th Oct 2013, www. doh.gov.uk/consent/index.htm.

Pacific R. Co. v *Botsford*[6]. In this case while rejecting the request of a railroad company to perform a surgical examination on a woman suing for injuries sustained in a fall, Justice Gray[7] stated:

> No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestioning authority of the law.

The legal principle of consent is the conceptual mechanism through which the patient's right to self-determination is guaranteed and safeguarded.[8]The legal requirement for consent expresses respect for patient's autonomy.[9] Consent to treatment is widely regarded as the cornerstone of the doctor-patient relationship.[10] The importance of the concept lies in the fact that it is essential to the protection of the patient's rights. Hence, the principle of consent forms the basis in providing treatment and, it is important to understand the concept. Also, without understanding the principle of consent it would not be possible to fully comprehend the approach taken by the courts when confronted with new scenarios and problems.[11]

The chapter examines the ethical underpinnings of the whole concept of consent and also the essential elements which have to be satisfied in order for a competent patient to give a valid consent. For a significant category of patients, informed consent is unattainable due to lack of mental capacity or maturity. These incompetent patients may be temporarily, or even permanently, incapable of exercising an autonomous choice regarding healthcare and thus, alternative means of authorizing treatment must be adopted. The chapter also discusses as to who makes healthcare decisions in respect of incompetent patients and on what basis.

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6 141 U.S. 250 (1891). The plaintiff sued Railway Company for negligence in the construction and care of an upper berth in a sleeping-car in which she was a passenger, by reason of which she suffered injuries. The defendant moved the court for an order against the plaintiff, requiring her to submit to a surgical examination stating that such examination was necessary to enable a correct diagnosis of the case, and that without such examination the defendant would be without any witnesses as to her condition. The court held that it had no legal right or power to make and enforce such an order.

7 Id. p. 250.

8 I Kennedy, "The Legal Effect of Requests by the Terminally Ill and Aged not to Receive Further Treatment from Doctors" in I Kennedy, *Treat Me Right*, Clarendon Press, Oxford (1988), p.387.

9 Jones, M, *Medical Negligence*, Sweet & Maxwell, London (1991), p.200.

10 Id.

11 M. Davis, *Textbook on Medical Law*, 2nd edn., Butterworths, London, (1998), p.126.

5.2. CONSENT TO TREATMENT

Consent means an agreement, compliance or permission given voluntarily without any compulsion. [12] It is a process of communication between a patient and physician that results in the patient's authorization or it may be an agreement to undergo a specific medical intervention. According to the Indian Contract Act two or more persons are said to consent when they agree upon the same thing in the same sense.[13] The Law perceives it as a contract. In medicine, the need for consent is the legal expression of the principles of self-determination and autonomy.[14]

Consent is a state of mind personal to the patient whereby he agrees to the violation of bodily integrity.[15] In *Re B*[16] the court have unreservedly accepted that a patient's bodily integrity is inviolable such that any physically invasive medical treatment or procedure, however trivial, is unlawful unless authorized by consent or other lawful authority. For a competent person, the making of his own decisions with respect to his own body is the legal expression of the principle of personal autonomy and of the right to self-determination. [17] The law protects the individual's right to self-determination even when the likely consequence is the person's death[18] and this right is absolute with regard to competent patients[19].

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12 Pillay VV, *Handbook of Forensic Medicine and Toxicology*, 13th ed., Paras Publication, Hyderabad (2003). pp. 24-5.

13 s.13, Indian Contract Act.

14 D. Feldman, "Human Dignity and Legal Values – Part II", 116 *LQR* 61(2000), p.67

15 *Sidway* v *Bethlem Royal Hospital Governors* [1985] 1 All ER 643, p.658, per Lord Diplock.

16 *Re B (Adult: Refusal of Treatment)* [2002] 2 All ER 449. B who had become tetraplegic, no longer wished to be kept alive by means of artificial ventilation. She asked for ventilation to be withdrawn but the doctors caring for her were unwilling to agree to this. B, whose mental capacity was unimpaired by her illness, sought and obtained a declaration from the court that the hospital was acting unlawfully. The Court of Appeal confirmed the common law right of a competent patient to refuse medical treatment, even though exercise of the right would result in the patient's own death. It is also held that if a competent patient's refusal is not respected, health professionals and hospitals face the prospect of award of damages being made against them for unlawful trespass.

17 *Nancy B* v *Hotel-Dieu de Quebec* (1992) 86 DLR 4th 385, 391. Nancy B. was surviving by means of artificial life support. In this case the Quebec Superior Court held that a patient was legally entitled to discontinue and decline the medical treatment she was offered when she found it unacceptable.

18 *Airedale NHS Trust* v *Bland* [1993] 1 All ER 821, 860 per Lord Keith. Tony Bland was in persistent vegetative state for three years and was being kept alive on life support machines. His brain stem was still functioning, which controlled his heartbeat, breathing and digestion, so technically he was still alive. However, he was not conscious and had no hope of recovery. The hospital with the consent of his parents applied for a declaration that it might lawfully discontinue all life-sustaining treatment and medical support measures designed to keep him alive in that state, including the termination of ventilation, nutrition and hydration by artificial means. The court granted the declaration.

19 *Re T (Adult: Refusal of Treatment)* [1992] 3 WLR 782,786 per Lord Donaldson.

Therefore, the right exists regardless of the consequences for the individual. The law's recognition and protection of the inviolability of the patient's bodily integrity includes the right to withdraw consent after it is given. In *Ciarlariello* v *Schacter*[20] the Canadian Supreme Court accepted that an 'individual's right to determine what medical procedures will be accepted must include the right to stop a procedure'. The court acknowledged that the right to withdraw consent was not absolute where the effect of termination would be either life threatening or pose immediate and serious problems to the health of the patient.[21] Consent could only validly be withdrawn if the patient was, in law, capable of doing so and the question whether a patient is capable of withdrawing consent will depend on the circumstances of each case.[22] As there is no relevant English case in this matter, it is presumed that the patient should give a valid consent to continuation and also would impose a duty to provide information relevant to that decision.

Without proper consent from a patient the doctor might end up facing legal liability for battery under tort or assault under law of crime.[23] A valid consent to treatment in healthcare context is essential to protect patient's autonomy as many forms of medical treatment involve an assault upon the physical integrity of the patient.[24] Consent has a legal, moral and a clinical function too. As Emily Jackson[25] notes:

> legally, consent will sometimes convert what would otherwise be unlawful touching into a lawful practice. Morally, consent is required in order to respect the patient's right to self-determination. Clinically, a patient's consent will make it easier to treat her, and her cooperation may contribute towards the treatment processes.

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20 (1993) 100 DLR (4th) 609 (SCC). The claimant was diagnosed with a suspected aneurism. She underwent a diagnostic cerebral angiogram. During the procedure she experienced discomfort and asked the doctor to stop, which he did. When she had calmed down, the claimant told the doctor to continue the procedure. She suffered a rare reaction to the dye which was injected during the course of the procedure. The claimant sued the doctor, for battery alleging that she had withdrawn her consent during the procedure and its continuation amounted to a battery. The Supreme Court dismissed her action for battery while accepting that a patient had a right to withdraw her consent during a procedure.

21 Id. p.618.

22 Id. pp.619-20.

23 It is to be noted that touching a person without his or her consent, however benevolently, is prima facie unlawful. Battery is the intentional application of physical contact to the person without consent or other lawful justifications. Where there was actual as well as apprehended unlawful force the charge is assault. See, *DPP* v. *Little* [1992] 1 All ER 299.

24 Andrew Grubb, *Principles of Medical Law*, 2nd edition, Oxford University Press, New York (2004), p.132

25 Emily Jackson, *Medical Law, Text, Cases and Materials*, 2nd edn, Oxford University Press (2010), p.217.

Consent does not offer a defense to the infliction of actual or grievous bodily harm.[26] For example, surgery involves cutting the body in a way which could undoubtedly be described as 'grievous bodily harm', and hence no defense of consent could be claimed. However, reasonable and proper surgical intervention for the benefit of the patient is accepted. In *Airedale NHS Trust* v *Bland*[27] , Lord Mustill held:

> ….bodily invasions in the course of proper medical treatment stand completely outside the criminal law. The reason why the consent of the patient is so important is not that it furnishes a defense in itself, but because it is usually essential to the propriety of medical treatment.

So it is a well established principle that, reasonable or proper medical treatment stands completely outside the criminal law. If a patient wishes to claim that their consent was not 'real', perhaps because they were not told what they were consenting to or because they were coerced into agreeing to the treatment, then an action for battery might be possible in civil law.[28] In practice, such actions are extremely rare. As we see later in the chapter that very few patients succeed in persuading a court that their apparent consent was defective due to lack of information, and also, coercion and undue influence are also unlikely to vitiate a patient's consent.

5.3. TYPES OF CONSENT

5.3.1. Express Consent

Express consent is where the patient demonstrates orally or in writing that he agrees to the treatment or procedure.[29] The Medical Council of India (MCI) has laid down guidelines that are issued as regulations in which consent is required to be taken in writing before performing an operation.[30] Unfortunately, the guidelines are applicable to operations and do not cover other forms of medical treatment.

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26 Id.

27 [1993] AC 789.

28 Emily Jackson, *Medical Law, Text, Cases and Materials*, 2nd edn, Oxford University Press (2010), p.219.

29 Andrew Grubb, *Principles of Medical Law*, 2nd edn., Oxford University Press, New York (2004), p.148.

30 Regulation 7.16, Medical Council of India (Professional Conduct, Etiquette and Ethics) Regulations, 2002. Before performing an operation the physician should obtain in writing the consent from the husband or wife, parent or guardian in the case of minor, or the patient himself as the case may be. In an operation which may result in sterility the consent of both husband and wife is needed.

In this type of consent, patient usually requires to sign a consent form provided by the concerned hospital. By signing this form, it is generally presumed that the doctor has explained the proposed treatment and the procedures involved. Thereby, the patient cannot deny later.[31] They do not, as is sometimes assumed within the medical profession, in themselves constitute a patient's consent.[32] Their function, in law, is purely evidentiary.[33] In *Chatterton v Gerson*[34] Bristow J[35] stated:

> I should add that getting the patient to sign a pro forma expressing consent to undergo the operation 'the effect and nature of which have been explained to me', as was done here in each case, should be a valuable reminder to everyone of the need for explanation and consent. But it would be no defense to an action based on trespass to the person if no explanation had in fact been given. The consent would have been expressed in form only, not in reality.

Hence, Consent expressed 'in form only' is no consent at all.[36] Mere signing of consent form is not an end in itself. The patient must receive sufficient and appropriate information from an evidential point of view.[37] An identical approach is called for in respect of forms which purport to record a patient's refusal of treatment, for example, of a blood transfusion. Speaking of such forms in *Re T*[38], Lord Donaldson MR stated:

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31 Picard, EI, "Legal Liabilities of Doctors and Patients in Canada", 2nd edn., Carswell, Toronto (1984),p.20, in Devereux, JA, *Australian Medical Law*, 3rd edn, Cavendish Publication, London (2007), p.139. A patient's consent need not be given in writing. The common law does not impose such a requirement, although in analogous circumstances statutory provisions may do so. For example, Human Fertilisation and Embryology Act 1990, Sch 3.

32 See generally, *Reference Guide to Consent for Examination or Treatment*, 2nd edn.,DoH (2009), p.16. viewed 7th Oct 2013, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/138296/dh_103653__1_.pdf. It should be noted that the purpose of obtaining a signature on the consent form is not an end in itself. The most important element of a consent procedure is the duty to ensure that patients understand the nature and purpose of the proposed treatment. Where a patient has not been given appropriate information then consent may not always have been obtained despite the signature on the form.

33 Id.p.8.

34 [1981] 1 All ER 257.

35 Id. 265.

36 Id. per Bristow J.

37 See *Williamson* v *East London and City HA and Others* [1995] Lloyd's Rep Med 6. The claimant underwent surgery following problems with silicone breast implants. The consent form had originally referred to a 'replacement breast prosthesis and right open capsulotomy', procedures less radical than a mastectomy. However, the operation that was eventually performed was subcutaneous mastectomy. After signing of the form, the surgeon found that the more radical surgery was required. The surgeon altered the original consent form but the form was not further signed by the claimant. It was found that the defendant had been negligent in not having explained the proposed treatment and held liable.

38 [1992] 4 All ER 649,663.

> They will be wholly ineffective… if the patient is incapable of understanding them, they are not explained to him and there is no good evidence (apart from the patient's signature) that he had that understanding and fully appreciated the significance of signing it.

Consent given in express terms includes the express terms the parties had agreed amongst themselves. This may include as to the payment and also the patient's choice of doctor who may carry out the proposed treatment upon the patient. In *Perna* v *Pirozzi*[39], it was held that a patient has the right to choose the surgeon who will operate on him and to refuse to accept a substitute. Correlative to that right is the duty of the doctor to provide his or her personal services in accordance with the agreement with the patient. It is implied by the form, however, that if the procedure is not carried out by doctor of his own choice then it will be carried out by some other doctor who is equally competent enough to carry out the treatment.[40]

Legal difficulties have arisen when a patient is unaware if he or she is treated by a medical student or for that matter sometimes even by nurses. A medical student may as part of getting experience or knowledge may examine a patient. This touching of the patient practically plays no part in the care of the patient. In such circumstances, the consent given by the patient is invalid since the identity of the person touching does not affect the nature of what is being done to the patient because he does so as part of his training rather than giving care to the patient. But, there are also circumstances when a medical student may examine a patient as part of his professional care. In such circumstances a question may arise as to whether the lack of awareness about the identity of the person who touches the patient affects the validity of his or her consent? According to Kennedy and Grubb[41] 'there could be no difference between a medical student, presumably supervised and a doctor unless the patient suffered harm and could establish that the medical student was negligent, an English court would reject any claim by a patient'.

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39 457 A 2d 431. Mr. Perna consulted Dr. Pirozzi, a specialist in urology, who recommended that he undergo surgery for the removal of kidney stones. Dr. Pirozzi was associated with a medical group that also included Drs. Del Gaizo and Ciccone. Mr. Perna executed a consent form that named Dr. Pirozzi as the operating surgeon and authorized him for carrying out surgery. But it was performed by other two doctors. Plaintiff alleged that there was a failure to obtain informed consent. The plaintiff was successful in suing defendant following surgery carried out competently and in accordance with patient's consent, but performed by different doctor to that expected by the patient.

40 Marc Stauch, Kay Wheat, John Tingle, *Sourcebook on Medical Law*, 2nd edn., Cavendish Publishing, London (2002), p.113.

41 Kennedy, I and Grubb, *A Medical Law*, 2nd edn, , Butterworths, London (1994), p.168.

A consent form contains express terms on which the parties have entered into an agreement. If there is written consent, the medical practitioner would have greater ease in proving consent in case of litigation. However, there are limits to what the parties may agree through express terms. In no way parties can enter into an agreement which would be regarded as contrary to public policy, for example, selling of an organ.[42]

5.3.2. Implied Consent

Implied consent is frequently relied upon by doctors as a justification for carrying out treatments or interventions upon patients. Implied consent is more properly understood as a species of estoppel.[43] Where a patient conducts himself such that it is reasonable to imply that he consented to the treatment or procedure, the law merely prohibits the patient because of his conduct from denying that he consented even though, in fact he did not.[44] The extent to which consent may be implied is, often, controversial. For example in *Mohr* v *Williams*[45] , a patient had consented to an operation on her right ear. During the course of the operation, the doctor discovered that the right ear did not, in fact, need surgery, but the left ear was in a more serious condition which required an operation. The doctor performed operation, which was successful. The patient sued in battery. The main issue before the court was whether it could be argued that she had given an implied consent to an operation on the other ear? The defendant argued that the fact that the patient had consented to the operation on her right ear was relevant to the lawfulness of the operation on the other ear. In other words, the suggestion was that the patient had consented to an 'ear operation'. But the judge took the view that there was no implied consent because the diseased condition of the patient's left ear was not

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42 Kennedy, I and Grubb, A, "Medical Law: Cases and Materials", 3rd edn, Butterworth, London (2000) in Devereux, JA, *Australian Medical Law*, 3rd edn, Cavendish Publication, London (2007),p.140.

43 *Sidaway* v *Bethlem Royal Hospital Governors* [1985] 1 All ER 643,658 per Lord Diplock. Where the patient so conducts himself in the circumstances that it is reasonable to conclude that he has consented to a treatment or procedure, the patient will not subsequently be permitted to rely on the fact that he did not actually consent. The doctor will have a defence to what would otherwise be an unlawful touching based upon the patient's implied consent. Implied consent is often utilised by doctors to justify treatment or interventions which are considered to be routine by the medical profession. For example, diagnostic tests are regularly performed during maternity care without the explicit consent of the patient. Use of medical records for research especially epidemiological research, procedures carried out by medical students as part of their training. Here to find an answer to what extent the patient has given consent will depend upon the circumstances.

44 Id.

45 (1905) 104 NW 12.

discovered in the 'course of an authorized examination' of the ear, but in the course of an examination which had not been authorized.

Most actions in which a patient sues for breach of contract arise in circumstances where the patient alleges that the medical practitioner has breached a term of the contract which was implied into the contract by virtue of the operation of the law. The test applied by the court in considering whether a term can or cannot properly be implied in a contract is that embodied in what is frequently called the doctrine of *The Moorcock* [46]. It is set out in Halsbury's Laws[47]:

> A term can only be implied if it is necessary in the business sense to give efficacy to the contract; that is if it is such a term that it can confidently be said that if at the time the contract was being negotiated someone had said to the parties, "What will happen in such a case", they would both have replied, "Of course, so and so will happen; we did not trouble to say that; it is too clear".

For example, in *O' Brien* v *Cunard Steamship Co*[48], the claimant was vaccinated against small pox by a surgeon on board a boat bound for Boston. She joined a line of passengers whom the surgeon was examining and vaccinating if necessary. When the surgeon told her she should be vaccinated she held out her arm and he did so. She sued claiming battery on the basis that she had not consented to the vaccination. The Supreme Judicial Court of Massachusetts dismissed her action. The court was influenced by the fact that notices had been posted around the ship in various languages that day to indicate the need for vaccination; the claimant had stood in line and seen what was happening to other passengers and she had not offered any

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46 (1889) 14 PD 64, [1886-90] All ER Rep 530. This is a leading English contract law case, which introduced the concept of implied terms. It is well known as the origin of the business efficacy test for terms implied in fact. The owners of the ship called The Moorcock contracted for space at a wharf owner's jetty in order to unload cargo. While docked the tide went down to a point where the hull of the ship hit a ridge causing damage to the ship. The plaintiff argued that the wharfingers were responsible to ensure that vessel would remain safe while docked. The wharf owners, in their defence, claimed that there were no provisions in the contract to ensure the vessel's safety nor could they have foreseen the damage caused to the vessel. The issue before the Court was whether there can be any implied warranty in the circumstances. The Court held that the wharfingers were responsible for the safety of the ship while docked. Bowen LJ stated that any implied warranties must be based on the presumed intentions of the parties. An implied warranty may be read into a contract for reasons of business efficacy and in order to maintain the presumed intention of the parties.

47 4th edn, para 355.

48 (1891) 28 NE 266.

objection to the surgeon when he went to vaccinate her. The court held that her consent should be implied from the circumstances and her conduct. Knowlton J said:

> If the claimant's behaviour was such as to indicate consent on her part, the surgeon was justified in his act, whatever her unexpected feelings may have been. In determining whether she consented, he could be guided only by her overt acts and the manifestations of her feelings.

However, in *Eyre v Measday*[49] the court held that where a doctor contracted to carry out a particular operation for a particular result, the court would imply into the contract between the doctor and the patient a term that the operation would be carried out with 'reasonable care and skill', but would be slow to imply a term that the expected result would actually be achieved, since it was probable that no reasonable medical man would intend to give such a warranty. Slade LJ[50], further stated:

> that in order to ascertain what was the nature and what were the terms of the contract, this court has to apply an objective rather than a subjective test. The test thus does not depend on what either the plaintiff or the defendant thought were the terms of the contract in her or his own mind. It depends on what the court objectively considers that the words used by the respective parties must be reasonably taken to have meant. It would, therefore, be of no assistance to the defendant to say that he did not intend to enter into a contract which absolutely guaranteed the plaintiff's future sterility. It would likewise be of no assistance to the plaintiff to say that she firmly believed that she was being offered a contract of this nature.

Further, in *Greaves & Co. (Contractors) Ltd* v *Baynham Meikle &Partners*[51], Lord Denning categorically stated that a professional man usually cannot guarantee that he will achieve the desired result. As this will not fit well with the universal warranty of reasonable care and skill, which tends to affirm the inexactness of the science which is

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49 [1986] 1 All ER 488. A woman consulted a gynecologist to arrange a sterilization operation. The gynaecologist stressed to the woman and her husband that such an operation was irreversible. At no time did he warn the woman of the 1% risk of the operation proving unsuccessful, exposing the woman to the risk of having more children. The woman underwent the operation. After resuming sexual relations with her husband, the woman conceived a child. A healthy child was subsequently born. The woman sued, alleging breach of a contractual term. The appeal was dismissed.

50 Id. p.492, 493.

51 [1975] 1 WLR 1095. In this case the defendants were expressly informed that the first floor was to take the weight of loaded fork lift trucks. The defendants had failed adequately to design for vibration and the floors consequently cracked. The Court of Appeal held that the defendant designers were in breach of an implied term that the design would be 'reasonably' fit for the purpose of the use of fork lift trucks.

professed. Moreover, of all sciences medicine is one of the least exact. Therefore, a doctor cannot be objectively regarded as guaranteeing the success of any operation or treatment unless he says as much in clear and unequivocal terms.

The importance the law places upon the inviolability of the patient's bodily integrity strongly points to the law requiring explicit consent. Hence, it would not be proper to imply that a patient by agreeing to the taking of blood agrees to being tested for HIV infection or genetic conditions.[52] The fact would have to be brought to the patient's attention or reasonable steps be taken to do so.[53] Traditionally, it has been argued that treatment of an unconscious or otherwise incompetent patient may be justified on the basis of implied consent.[54] As regards the former, it has been said that the patient would agree to an intervention which was in their 'best interests' if they were able and so their consent to the intervention may be implied.[55] Clearly, the implication or inference of consent is inappropriate where the patient is unable to consent due to incompetence. It is particularly artificial in the case of patients whose mental disability is permanent to justify, for example, sterilization of mentally disabled women.[56] The more appropriate legal justification in these cases is the principle of necessity as recognized by the House of Lords in *Re F*.[57]

The law of consent requires that the patient authorize the procedure which is carried out. A procedure may be unauthorized for a number of reasons and, subject to what is said below; in such circumstances the doctor will commit a battery. It is the patient, not the doctor, who decides whether the surgery will be performed, where it will be done, when it will be done and by whom it will be done.[58] Therefore, whether a patient will be taken to have impliedly consented to a particular treatment or procedure will be a question of fact in every case. Where a

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52 Andrew Grubb, *Principles of Medical Law*, 2nd edn, Oxford University Press (2004), p.151.

53 See for example, in *Turner* v *Royal Bank of Scotland* [1992] 2 All ER 664 (CA). The English Court of Appeal has held that there is no implied consent from the customer for the bank to give a "bankers' opinion", also known as a "banker's reference" to another bank. The defendant bank had given such a reference without obtaining the plaintiff's express consent.

54 Skegg, PDG, "A Justification for Medical Procedures Performed Without Consent", 90 *LQR* 512 (1974).

55 See e.g., *Mohr* v *Williams* (1905) 104 NW 12 (Minn Sup Ct.).

56 See, *Re F(Mental Patient: Sterilisation)* [1989] 2 All ER 545,563 per Lord Goff.

57 Id.

58 *Allan* v *New Mount Sinai Hospital* (1980) 109 DLR (3d) 634, 642 per Linden J. In this case though the petitioner had agreed to have an injection in his right arm, it was given in his left arm by the doctor. Allan was successful in his claim for damages.

reasonable person looking on to the situation would conclude that the patient had agreed to the intervention, even if the patient has not, the doctor will have a defense based upon implied consent.[59]

From the discussions, it is clear that consent is a state of mind of the patient. As Andrew Grubb[60] notes 'a valid legal consent is given even where the patient does not demonstrate his agreement providing that the state of his mind was, in fact, that he agreed'. In other words, an unexpressed actual consent is, in law, a valid consent. However, there may be evidential difficulties in establishing the patient's actual consent if it is not expressed but this does not detract from the analysis of what consent, in law, really is.[61]

5.4. THE COMPONENTS OF CONSENT

For consent to treatment, or to a refusal of treatment, to be legally valid it must be made by a person with competence, adequate information and voluntarily without coercion or under undue influence. To be competent to give a legally effective consent, the patient must be endowed with the ability to weigh risks and benefits of the treatment that is being proposed to him. The law presumes that such ability is generally acquired with the attainment of age of so called maturity. Many countries have legislated age for giving valid consent for medical examination and procedures. But unfortunately the Indian Statutes does not contain separate legislation regarding consent to medical treatment nor do the various statutes relating to majority, minority and guardianship throw any light on the subject. As a result, the laws for consent in general are also being applied to the medical profession. According to the Indian Majority Act, persons who have attained the age of eighteen are generally considered to be competent to give consent.[62] Hence, a person who has attained the

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59 See, e.g, *Canadian AIDS Society* v *Ontario* (1995) 25 OR (3d) 388. In this case the Canadian AIDS Society sought a declaration that Health Protection and Promotion Act (HPPA) and the Laboratory and Specimen Collection Centre Licensing Act (LSCCLA), which required that blood donors and public health authorities be notified if the donor is HIV positive, violated the donor's right to life, liberty, security and be free from search and seizure. The Court dismissed the application, finding that the testing of the donor's blood and disclosure of the donor's HIV status to public health authorities may infringe the right to life, liberty, security and be free from search and seizure, but the infringement was neither contrary to the principles of fundamental justice nor unreasonable.

60 Andrew Grubb, *Principles of Medical Law*, 2nd edn, Oxford University Press (2004),p.148

61 Id.

62 See the Indian Majority Act, 1875 (9 of 1875).

age of eighteen and who has sound mind can give valid consent to the medical practitioner for any treatment. This therefore excludes children.

There are instances where a patient in spite of attainment of legally competent age finds unable to consent to medical treatment. These patients may be categorized as unconscious or mentally incompetent. In relation to children, proxy consent may suffice as even a *Gillick* competent child does not have the ability to withhold consent.[63] According to common law principles proxy consent is not an option for an adult patient who is incompetent. The following paragraph highlights the ethical and legal dilemmas faced by the doctors and courts in determining the competency of patients and also in determining who has the ultimate say in treatment decisions for the incapacitated patients.

5.4.1. Capacity

Capacity is linked to the significant value of respect for autonomy, which is 'the authority to make decisions of practical importance to one's life, for one's own reasons, whatever those reasons might be'.[64] Capacity is a legal concept that describes the level of intellectual functioning a person requires to make and accept responsibility for important decisions that often have legal consequences.[65] The medical perspective is concerned with cognitive ability to comprehend, remember and reason rationally.[66] There are no definitive, scientific tests for use when assessing whether a person meets a particular capacity standard. The law has not devised a uniform standard for the level of cognitive ability a person requires in order to have capacity to legally participate in many of the activities of everyday life. Courts have often emphasized that capacity assessments are ultimately

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63 *Re R (A Minor)(Wardship: Medical Treatment)* [1991] 4 All ER 177.

64 Catriona Mackenzie, "Relational Autonomy, Normative Authority and Perfectionism" 39 *Journal of Social Philosophy* 512 (2008).

65 Victorian law reform commission report on Guardianship, 18th April 2012, p.99, viewed 12th Sep 2013, http://www.lawreform.vic.gov.au/sites/default/files/Guardianship_FinalReport_Ch%207_Capacity%20and%20incapacity.pdf.

66 Terry Carney, 'Guardianship, Citizenship, & Theorizing Substitute Decisionmaking Law' in I Doron and A Soden, *Beyond Elder Law: New Directions in Law and Ageing* , Springer (2012), p.2

questions of fact for judicial officers and tribunal members when the issue of a person's capacity arises in the course of legal proceedings.[67]

The numerous legal rules concerning capacity have developed over time and without coordination. Discussions below will make clear that each area of law has developed its own standard for deciding whether a person is unable to participate in an activity on the same terms as other people because they lack capacity. In most instances, capacity standards exist to protect vulnerable people and ensure fair transactions.

5.4.1.1 *Competency in Children*

Childhood was traditionally conceived as a period of lack of responsibility, with rights to protection and training but not to autonomy.[68] This is because complete development of an infant's physical powers takes many years. His intellectual faculties are slower. Infants also do not have necessary experience to control their passions.[69] Being sensitive to instant impulses, they may take decisions quite hastily.[70] The feebleness of infancy thus demands a continual protection.[71] No doubt to an infant, the immediate authority is his or her parents.[72] But, decline in familial relationship has reduced the influence that parents had over children and their decisions.[73] Children are now found to be more mature, self-aware and financially independent than they were in the past.[74] Thus, one can easily make out that childhood is a disappearing phenomenon in the modern world.[75] This section firstly explores how far it is feasible to recognize the right of children to participate in decision-

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67 Victorian law reform commission report on Guardianship, 18th April 2012,p.101, viewed 12th Sep 2013, http://www.lawreform.vic.gov.au/sites/default/files/Guardianship_FinalReport_Ch%207_Capacity%20and%20incapacity.pdf.

68 Judith Ennew, *The Sexual Exploitation of Children*, Polity Press, Cambridge (1986),p.21.

69 J. Bentham, *Theory of Legislation*, Boston (1840), p.248 in Joseph Goldstein, "Medical Care for the Child at Risk: On State Supervention of Parental Autonomy", 86 *Yale L.J.* 645, 1977, p.645-46.

70 Id.

71 Id.

72 Joseph Goldstein, "Medical Care for the Child at Risk: On State Supervention of Parental Autonomy", 86 *Yale L.J.* 645 (1976), p.646.

73 Postman N, *The Disappearance of Childhood* , Vintage, New York (1994), p.120

74 L Thomson, "Whose right to choose? A competent child's right to consent to and refuse medical treatment in New Zealand" (2001) 8 *Canterbury L Rev* 145, 161.

75 Postman N, *The Disappearance of Childhood* , Vintage, New York (1994), p.120. There is, for example, the evidence displayed by the media themselves, for they not only promote the unseating of childhood through their form and context but reflect its decline in their content. There is evidence to be seen in the merging of the taste and style of children and adults, as well as in the changing perspectives of relevant social institutions such as the law, the schools and sports. And there is evidence of about alcoholism, drug use, sexual activity, crime etc., that imply a fading distinction between childhood and adulthood.

making and as to whether they have legal competence and to what extent can children express their views and participate in medical decision-making? Secondly, although parents and physicians have traditionally made most medical decisions on behalf of children, the developing autonomy of children is increasingly being recognized in medical decision-making too. This poses a challenge for physicians, who must work with the child's family and with other health care practitioners to determine child's role in decision-making. Hence, it focuses on its implications over the right of parents over their children and the role of physicians and courts.

5.4.1.1.1. *Right to Participate in Decision-Making*

The most prominent UN manifestation to advance children's rights is the Convention on Rights of Child (CRC).[76] The CRC, incorporates the full range of human rights i.e., civil, cultural, economic, political and social and, creates an international foundation for the protection and promotion of human rights and fundamental freedoms of all persons under the age of 18.[77] The Convention represents widespread recognition that children should be fully prepared to live an individual life in society, and brought up in the spirit of peace, dignity, tolerance, freedom, equality and solidarity.[78] However and more importantly, it is characterized by four main principles which serve as indicators to what States Parties must strictly adhere to. They are the principle of non-discrimination[79], the

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[76] The Convention was adopted by Resolution 44/252 of 20 November 1989 at the Forty-fourth Session of the UN General Assembly, and entered into force on 2 September 1990, in accordance with Article 49(1) of the CRC.

[77] Art.1 of CRC defines a child as 'every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier'.

[78] Fottrell, D, *Revisiting Children's Rights. 10 Years of the UN Convention on the Rights of the Child*, Kluwer Law International (2000), p.11.

[79] Art.2 reads thus:
1. States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.
2. States Parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions, or beliefs of the child's parents, legal guardians, or family members.

principle of the best interest of the child[80], the right to life, survival and development[81] and the right for a child's opinion[82].

Recognition of rights under CRC has led to support for children's rights even in the field of medical care.[83] Personal rights of bodily integrity, autonomy, dignity and privacy of a child must be respected in the medical sphere. Health care decisions involve choosing between various therapeutic options, weighing up relative advantages and disadvantages.[84] Participation gives expression to the acknowledgment that children are capable of voicing an opinion.[85] But, one requires a minimum standard of skill to make a choice in healthcare. This is essentially considered to be the capacity of a person.[86] While an adult is presumed to have necessary legal capacity to make choices in medical treatment,[87] a minor is not supposed to have it. However, there may be situations where child may be able to make legitimate choices in this respect. Legal

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80 Art.3 reads thus:
1. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.
2. States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures.
3. States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.

81 Article 6 reads thus:
1. States Parties recognize that every child has the inherent right to life.
2. States Parties shall ensure to the maximum extent possible the survival and development of the child.

82 Article 12 reads thus:
1. States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

83 See Articles 12(1) and 24(1) United Nations Convention on the Rights of the Child.
Article 12(1) reads thus*:*
1. States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.
Article 24(1) reads thus*:*
1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

84 Emily Jackson, *Medical Law* Text, *Cases and Materials*, 2nd edn, Oxford University Press (2010), p.169

85 To what extent they can do so, is still being questioned. After all, different arguments concerning the competences of children exist.

86 Wicks, Elizabeth, *Human Rights and Healthcare*, Hart Publishing, Oregon (2007), p.72.

87 See, *Schloendorff* v *New York Hospital*, 1914 N.Y. LEXIS 1028 .Cardozo J stated 'every human being of adult years and sound mind has a right to determine what shall be done with his own body'.

validity of such choices is a moot question because the law is not certain as to when a child achieves competence to consent to or to refuse treatment. It is clear that a baby or very young child is not able to give informed consent. However, the position concerning older children is far from certain.

For example, according to WHO, until recently it has been an 'almost universal rule' that children must have the consent of a parent or other adult before they can obtain health care and advice. Whether or not a minor has capacity and is therefore competent to consent to medical treatment is a question of law. Some countries have enacted legislation, while others rely on the common law to determine this issue. In England, in *Gillick* v *West Norfolk and Wisbech Area Health Authority* [88] the House of Lords formulated the concept known as '*Gillick* competence'. This concept was implemented in the Children Act, 1989, which is not only more child-centered, but the clearest recognition yet of the decision-making capacities of children.[89] In New South Wales[90] and South Australia[91], however, the age of consent for making decisions regarding medical treatment has been amended

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88 [1985] 3 All ER 402.

89 For example S.1(3)(a) of The Children Act, 1989, reads thus:
In the circumstances mentioned in subsection (4), a court shall have regard in particular to—
(a) the ascertainable wishes and feelings of the child concerned (considered in the light of his age and understanding).

90 See, Minors (Property and Contracts) Act 1970 (NSW), S. 49 reads thus: (1) Where medical treatment or dental treatment of a minor aged less than sixteen years is carried out with the prior consent of a parent or guardian of the person of the minor, the consent has effect in relation to a claim by the minor for assault or battery in respect of anything done in the course of that treatment as if, at the time when the consent is given, the minor were aged twenty-one years or upwards and had authorised the giving of the consent.
(2) Where medical treatment or dental treatment of a minor aged fourteen years or upwards is carried out with the prior consent of the minor, his or her consent has effect in relation to a claim by him or her for assault or battery in respect of anything done in the course of that treatment as if, at the time when the consent is given, he or she were aged twenty-one years or upwards.
(3) This section does not affect:
(a) such operation as a consent may have otherwise than as provided by this section, or
(b) the circumstances in which medical treatment or dental treatment may be justified in the absence of consent

91 See, Consent to Medical Treatment and Palliative Care Act 1995 (SA), S. 6, reads thus:
A person of or over 16 years of age may make decisions about his or her own medical treatment as validly and effectively as an adult.
The test in South Australia has been modified by Consent to Medical Treatment and Palliative Care Act,1995 (SA), S. 12 states: A medical practitioner may administer medical treatment to a child if-
(a) the parent or guardian consents; or
(b) the child consents and—
(i) the medical practitioner who is to administer the treatment is of the opinion that the child is capable of understanding the nature, consequences and risks of the treatment and that the treatment is in the best interest of the child's health and well-being; and
(ii)that opinion is supported by the written opinion of at least one other medical practitioner who personally examines the child before the treatment is commenced.

by legislation to fourteen and sixteen respectively. Similarly, Age of Legal Capacity (Scotland) Act, 1991[92] stated that a person under the age of 16 years shall have legal capacity to consent on his or her own behalf to any surgical, medical or dental procedure or treatment where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment.

Article, 12 of CRC is often seen as extreme and radical in its application to children as discontent was fostered due to a fear that rights of the child would be promoted at the expense of parents and the family.[93] Article 12 of CRC in itself is relatively general in nature yet it does address issues that are disputable. For example, its reference in paragraph one to giving children's view 'due weight in accordance with the age and maturity of the child' can be contested. Article 12 of CRC is linked to Article 3 which emphasizes best interest of the child. Also, there is little judicial authority on the rights of a child in a medical context and the courts have yet to address the question whether a child's personal rights, and capacity to make a decision, could take precedence over a parent's decision? This uncertainty has contributed significantly to the apprehension some health-care providers have towards treating or not treating children in the absence of parental consent or against the wishes of the parents.

5.4.1.1.2. *Test of Competence*

When it comes to taking decisions on behalf of children, it is the parents and physicians who make medical decisions as they are considered to be incapable by reason of their immaturity.[94] However, just as the concept of informed consent has developed over the years with respect to competent adult patients, so too new ways of thinking about the role of children in medical decision-making also have evolved.

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92 See, s. 2(4) of the Age of Legal Capacity (Scotland) Act, 1991.

93 Fottrell, D, *Revisiting Children's Rights. 10 Years of the UN Convention on the Rights of the Child*, Kluwer Law International, (2000), p.5.

94 *Rogers* v *Whitaker* (1992) 175 CLR 479, 489. In this case a woman who wanted to return to work sought advice from an ophthalmic surgeon as she had suffered an eye injury years before which left her partially blind. She was told there was nothing that could be done to restore her sight, but there was scope for cosmetic improvement. Prior to the operation, she asked three times if there was anything that could go wrong and was reassured that no serious complications were associated with the surgery. Unfortunately, she developed sympathetic ophthalmitis in her good eye and was rendered totally blind.

In *Gillick* v *West Norfolk & Wisbech Area Health Authority*[95] , the House of Lords held that a child can consent to medical treatment if he or she achieves sufficient understanding and intelligence to enable him or her to understand fully what is proposed. Though, *Gillick* case dealt with children's ability to receive contraceptive treatment and advice independently of parents, its relevance to the· consent of a child to all medical treatment is widely recognized.[96]The *Gillick* decision is strongly in favor of individual autonomy. It adopts a functional approach to the issue of consent and holds that if a patient is mentally competent to make a decision regarding treatment then that decision should be respected regardless of the patient's age.[97] The importance of the decision is well captured by Bainham's comment that, 'on the occasions when the judiciary recognize that children have rights it is considered a matter of some note'.[98]Thus, in common law the notion of 'mature minor' or '*Gillick* competence' recognizes that some children are capable of making their own health care choices.[99]

5.4.1.1.3. *Parental Responsibility*

Where the patient is an infant, the medical profession accepts that a parent having custody and being responsible for the infant is entitled on behalf of the infant to consent to or reject treatment if the parent considers that the best interests of the infant so requires[100]. If a child lacks capacity, consent to medical treatment will

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95 *Gillick* v *West Norfolk &Wisbech Area Health Authority*, [1985]3 All ER 402. It is to be noted that in this case no specific treatment had already been carried out for which proof of a valid consent was sought as a defence to a claim for trespass. The case concerned a guidance issued to local authorities by the relevant government department about the circumstances in which it was appropriate to give contraceptive advice to girls under the age of sixteen. The Guidance also included circumstances in which such advice could be given without knowledge and consent of parents. This case introduced the concept of *Gillick* competence. The concept applies to any type of medical treatment.

96 Les Moran, "A Reading in Sexual Politics and Law: Gillick v West Norfolk and Wisbech Area Health Authority and Another", 7 *Liverpool LR* 83 (1986), p.87.

97 See, Wicks, Elizabeth, *Human Rights and Healthcare*, Hart Publishing, Oregon (2007), p.112.

98 A Bainham, "The Balance of Power in Family Decisions" (1986) *CLJ* 262 quoted in Graeme Austin, Righting A Child's Right To Refuse Medical Treatment Section 11 of the New Zealand Bill of Rights Act and the *Gillick* competent child, 7 *Otago Law Review* 578 (1992), p. 586.

99 Rozovsky LE, Rozovsky FA, *The Canadian law of consent to treatment*, Butterworths, Toronto (1992), p.:55-6.

100 *Gillick* v *West Norfolk &Wisbech Area Health Authority*, [1985]3 All ER 402, 432. See also, Art.5 of UN Convention on the Rights of the Child which provides that the State must respect the rights and responsibilities of parents, or other caregivers, to provide 'appropriate direction and guidance in the exercise by the child of their rights in a manner consistent with the evolving capacities of the child'. This provision reflects the view that parental rights and responsibilities must also take account of the evolving capacities of the child.

usually be provided by the child's parents or guardian, save for exceptional circumstances where a doctor can proceed without consent such as emergency, parental neglect, abandonment of the child or an inability to find the parents.[101] If doctor and parent disagree, the court can decide.[102] Moreover, most medical decisions made by parents on behalf of their children will be non-controversial. However, in certain areas, such as control of fertility, there can be a real conflict between parental wishes and the interests of the child. This shows that parental power to consent to medical treatment on a child's behalf diminishes gradually as the child matures and his or her capacities grow.[103] This rate of development depends upon each individual child.[104] The decision in *Gillick* v. *West Norfolk and Wisbech Area Health Authority*[105] limited the power of parents to make decisions for their mature children. By rejecting the parental rights argument in *Gillick* case Lord Scarman[106] held that:

> Parental rights clearly do exist, and they do not wholly disappear until the age of majority. Parental rights relate to both the person and the property of the child: custody, care and control of the person and guardianship of the property of the child. But the common law has never treated such rights as sovereign or beyond review and control. Nor has our law ever treated the child as other than a person with capacities and rights recognised by law. ....parental rights are derived from parental duty and exist only so long as they are needed for the protection of the person and property of the child.

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101 Id . p.424

102 Id . p. 432

103 *Secretary, Dept. of Health and Community Services* v *JWB* (1992) 175 CLR 218, para 20. The child in this case suffered from intellectual disabilities, severe deafness, epilepsy and other disorders. Her parents sought an order from the Family Court of Australia authorizing them to have Marion undergo a hysterectomy and an oophrectomy, the practical effect would be sterilisation and preventing Marion from being able to have children, and also many of the hormonal effects of adulthood.

104 Id. see, para 24

105 *Gillick* v *West Norfolk &Wisbech Area Health Authority,* [1985] 3 All ER 402.

106 Id. p.423. With regard to the right of parent over children Lord Scarman stated the following general principle that parental right yields to the child's right to make his own decisions when he reaches a sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision.

Not surprisingly one finds that the courts at least in some situations recognize that there are limits to the rights of a parent. For instance, in *Re S*[107] while deciding on imposing religious belief of parent over their child Thorpe J said that the test must remain 'welfare of the child' and it is difficult to pursue the argument that the religious convictions of the parents should deny child the chance of treatment. Similarly, in *Re B*[108] it was laid down that if a treatment is in the child's best interests, the parent's refusal will be overridden. In this case B suffered from Down's syndrome and had an intestinal blockage, which required an immediate operation. The parent's decided that it is better for the child to die rather than continuing with a life of physically and mentally handicapped person. The Court of Appeal while overturning the wishes of parents' stated:

> Fortunately or unfortunately, in this particular case the decision no longer lies with the parents or with the doctors, but lies with the court. It is a decision which of course must be made in the light of the evidence and views expressed by the parents and the doctors, but at the end of the day it devolves on this court in this particular instance to decide whether the life of this child is demonstrably going to be so awful that in effect the child must be condemned to die, or whether the life of this child is still so imponderable that it would be wrong for her to be condemned to die.

In *Re J*[109] the Court of Appeal while refusing an application by a child's father that the child be circumcised, held that it would not be in the best interests as a non-practising Muslim, to undergo irreversible, non-therapeutic surgery which carried with it pain and small risk of psychological harm. In *C*[110] the Court of Appeal held that the child could be tested for HIV against the wishes of parents affirming that the wishes of the parents could be overruled. A child's 'best interests' may be determined by a range of

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107 *Re S (A Minor) (Medical Treatment)* [1993] 1 FLR 376. The child was suffering from leukaemia treatable only by blood transfusions. As the parents of the child were Jehovah Witnesses they opposed blood transfusion. The local authority invoked the inherent jurisdiction of the court under s 100 of the Children Act 1989 and sought an order permitting such treatment to be given.

108 *Re B (A Minor) (Wardship: Medical Treatment)* [1981] 1WLR 1421, CA.

109 *Re J (Childs Religious Upbringing and Circumcision)* (1999) 52 BMLR 82. In this case the child's parents had separated and the mother had custody. Father was a non-practising Muslim. Similarly, the mother was described as non-practising Church of England. Moreover, the child went to a secular school.

110 *C (HIV Test)* [1999] 2 FLR 1004. In this case mother was HIV positive and had taken all precautions to prevent transmission of the virus to the child, both during pregnancy and afterwards. The local authority made an application for a order that the child be tested which was objected by both the parents.

factors. In some cases involving children, the broader assessment of the child's welfare or best interests may weigh against medical treatment and the application of the principle of the sanctity of life. In the case of *Re T*[111], the Court of Appeal held that prolongation of life is not the sole objective of the court and decided that it was not in the child's best interests to undergo major invasive surgery with which the mother did not agree. The court found that the child's welfare could be better served by letting his parents make their own decisions about his future treatment. Similarly, in *Re C*[112] it was laid down that parents' view would be tantamount to requiring doctors to undertake a course of treatment.

Hence, it cannot be said that parents have an inalienable and legally enforceable right against their children. The true basis for the parental power to consent was identified by Justice McHugh in *Secretary, Dept. of Health and Community Services* v *JWB & SMB*[113] as being the child's right of advancement. Explaining the basis further, he said both the interests of the child and the interests of society require that, wherever possible, a child should not be deprived of medical treatment that is for his or her benefit.[114] A just and rational legal system must give a person authority to act on behalf of children only in respect of matters in which they are unable to act for themselves.[115] As Denham J in *North Western Health Board* v *HW & CW*[116] stated 'the child has rights both as part of the unit of the family and as an individual'.

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111 *Re T (A Minor) (Wardship:Medical Treatment)* [1997] All ER 906. The case deals with a child born with life-threatening liver defect. Without a liver transplant, it was thought that the child would not live beyond the age of two. The parents, who were both well-informed health professionals, decided they did not want their child to undergo a liver transplant operation as the proposed operation would have caused the child great pain and distress.The parents moved overseas, and the Local Authority applied for an order to force the parents to return to England and let their child have the operation. At first instance the judge granted the local authority's application and ordered the mother to attend hospital for transplant assessment.

112 *Re C (A Minor)* [1998] 1 Lloyd's Rep Med 1. A 16 month old baby was ventilated to support her own breathing. The opinion of the consultant paediatric was that no further ventilation should take place, and if, following withdrawal of the ventilation, the child may have respiratory arrest and need resuscitation. The parents, orthodox jews, supported for removal of ventilation, but did not agree for resuscitation.

113 See, para 16.

114 Id.

115 Id.

116 [2001] IR 622, 718. The Irish Supreme Court declined to intervene to override the refusal of the parents to give their consent to allow a doctor to carry out the 'heel prick' PKU blood test on their baby boy because it was not clearly evident that the refusal threatened his life or immediate health.

One cannot completely ignore the role played by parents in children's development as a whole. Therefore, law should give parents a wide discretion to guide their children and pursue family goals that extend beyond the goals of its individual members.[117] While the courts continue to emphasize the role of parents as the adults primarily responsible for their child's safety, health and well-being, it is also now expected that family life, and a parent's role in that family, will accommodate respect for children's growing maturity and their right to participate in decisions affecting them.[118] In other words, parental right to decide coexist with a children's right to decide.

5.4.1.1.4. *Role of Doctors*

While accepting that in the majority of cases it is the parents who are considered as best judges to determine welfare of a child; there may be circumstances in which the doctor is a better judge than a parent.[119] Lord Fraser in *Gillick* v *West Norfolk and Wisbech Area Health Authority*[120] suggested a five point test for doctors contemplating whether to provide contraceptive advice and treatment without reference to parents. The proposed test are firstly, where the doctor feels that a child is capable enough to understand his advice[121]; secondly if the girl is under the influence of her sexual partner or for some other reason there is no realistic prospect of her abstaining from intercourse[122]; thirdly, there may a circumstance where a doctor becomes incapable to persuade a child to inform his or her parents or to allow him to inform the parents that she is seeking contraceptive advice[123]; fourthly, unless contraceptive advice or treatment is received her physical or mental health or both

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117 L.F.Ross, "Health care decision making by children: is it in their best interests?" (1997) 27 *Hastings Centre Report* 41, p.43.

118 *Axon* v *Secretary of State for Health and Family Planning Association* [2006] QB 539. The claimant in this case sought a declaration from court that a doctor was under no obligation to keep confidential advice and treatment proposed to a young person, under the age of sixteen, in respect of contraception, sexually transmitted infections and abortion and must therefore inform the parents unless to do so would or might prejudice the child's physical or mental health, so that it is in the child's best interests not to do so. See also, Committee on the Rights of the Child "Implementing Child Rights in Early Childhood" (General Comment No. 7 of 2005 CRC/C/GC/7 Rev 1), p. 17. General Comment stated that parents and others should be encouraged to offer guidance in ways that enhance young children's capacities to exercise their rights, including their right to participation and freedom of thought, conscience and religion.

119 *Gillick* v *West Norfolk &Wisbech Area Health Authority*, [1985] 3 All ER 402, 412

120 Id.

121 Id. p. 413

122 Id.

123 Id.

are likely to suffer[124] and lastly if best interests require him to give her contraceptive advice, treatment or both without the parental consent.[125] If these tests are satisfied then it is desirable for a doctor to give contraceptive advice and treatment if necessary without the consent or even the knowledge of parents. This does not mean that doctors are given license to disregard the wishes of the parents whenever they find it convenient to do so.[126]As mentioned earlier there is no fixed way of assessing *Gillick* competence. The following extract from Lord Scarman's[127] decision proves the above argument.

> The law relating to parent and child is concerned with the problems of growth and maturity of the human personality. If the law should impose upon the process of'growing up' fixed limits where nature knows only a continuous process, the price would be artificiality and a lack of realism in an area where the law must be sensitive to human development and social change.

Further, not only does a '*Gillick* competent' child have to attain a higher threshold of understanding than a competent adult by virtue of the common law tests, but the '*Gillick* competent' child's intelligence and maturity must be tested, checked and approved to ensure that the common law requirements are satisfied. In medical law, assessing competence is the doctor's responsibility. Accordingly, a doctor must be entrusted with the power of discretion to act in accordance with his view of what is best in the interests of the patient.[128] As Lord Fraser notes, medical profession in modern times has come to be entrusted with very wide discretionary powers going beyond the strict limits of clinical judgment.[129] No fixed age attaches to this legal principle and, as a consequence, the test for capacity imposes a significant onus and discretion upon the treating professional's assessment of the minor.[130] It will be determined by a health practitioner's own experience and style. Sometimes, this might produce a very undesirable result and children who are competent to consent

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124 Id.
125 Id.
126 Id
127 Id. p. 421.
128 Id
129 Id
130 *Re Alex (Hormonal Treatment for Gender Dysphoria)* (2004) 31 FamCA 297, para.155. Alex was diagnosed as having gender identity dysphoria. She had a profound and longstanding wish to undergo a transition to become male in appearance. The application asked the Court to authorise medical treatment involving the administration of hormonal therapies.

will be given treatment only if their decision accords with the doctors' own opinions of their best interests. Furthermore, there is a concern within the medical community that there will be inconsistency in the application of *Gillick* due to personal views and beliefs.[131] This may be particularly noticeable in areas that raise social, religious or moral issues such as contraception, vaccinations and blood transfusions.[132] There is an additional problem if a doctor has wide discretions. A doctor who did not seek to ascertain the express or known wishes of the parents, or disregarded their wishes, or failed to try to persuade a child to consult or compromise with the parents, might be failing in his or her professional duties. This could make the doctor liable to professional disciplinary action. If he or she has a duty to assess the child's 'best interests', the decision might also expose him or her to civil liability at the suit of a parent, or even a child who later repented of a youthful decision. And if a mature child can give consent, then that consent is necessary even if the parent consents, so a medical practitioner must consider a child's maturity in every case. On any reading of *Gillick* case it is found that doctors who have to make such decisions are left with considerable, and perhaps unwelcome, discretionary power. As McLean, Kathryn[133] notes:

> A doctor should not overrule a Gillick - competent child's consent and deem them incompetent because the doctor believes that such treatment is not in the patient's best interests. However, a doctor may decline to administer treatment if he or she considers that it would be damaging to the patient. It is more appropriate, honest and ethical for a doctor in such a situation to refuse to administer treatment on the grounds that it would be unconscionable for him or her to proceed.

From the *Gillick* principle one can infer that a child who has both the understanding and requisite intelligence to make his or her own decisions, it is fundamental that neither the Courts nor the medical profession stand in his or her way.[134] In other words, once the determination of 'Gillick competence' has been made, the child's decision should be respected, regardless of the consequences, and not overridden by the court. But subsequent cases have pointed out that the views of a person under the

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131 McLean, Kathryn, "Children and Competence to Consent: Gillick Guiding Medical Treatment in New Zealand", 31 *VUW Law Rw* 551 (2000).

132 Id.

133 Id.

134 *Gillick* v *West Norfolk &Wisbech Area Health Authority*, [1985]3 All ER 402.

age of 16 cannot be equated with those of an 18 year old, who has actually reached the age of majority. As competence depends on the particular abilities of the individual child, a child may be competent to make autonomous decisions in some areas but not others. Ultimately, the decision on providing treatment and advice had to be taken on the principle identified by Lord Fraser i.e. 'welfare of the child'.[135] Hence, the care of children can be described in terms of a 'triadic' relationship in which the child, his or her parents and the physician all have a necessary involvement. When there is disagreement between parent and child, the physician may experience some moral discomfort in having to deal separately with the child and parent.[136] The assumption that parent's best understand what is in the interest of their child is usually sound. However, situations can arise in which the parents' distress prevents them from attending carefully to the child's concerns and wishes. Simply complying with the parents' wishes in such cases is inadequate. It is more helpful and respectful of the child to affirm the parents' responsibility for the care of their child while allowing the child to exercise choice in a measure appropriate to his or her level of development and experience of illness and treatment.[137] This approach does not discount the parents' concerns and wishes, but recognizes child as a particular patient to whom the physician has a primary duty of care.[138] This approach seeks to harmonize the values of everyone involved in making the decision.[139]

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135 The Law Reform Commission Of Western Australia, *Medical Treatment For Minors*, Discussion Paper, June 1988, para 3.9. The welfare approach is considered as a paternalistic one which may give some recognition to the obligation to consult and listen to the child but does not give the child a right to decide his or her own treatment. It depends on a perception of what is good for children, which is socially defined and therefore changes from time to time. But for the purposes of ensuring individual autonomy for child the term welfare must be read in its broader sense i.e. a decision has to be taken by doctors as well as courts after considering all the circumstances. See also, *Secretary, Dept. of Health and Community Services and JWB* (1992)175 CLR 218 at para 154.

136 Christine Harrison, "Bioethics for clinicians: Involving children in medical decisions", 6 *Can Med Assoc J* 825 (1997), p. 826.

137 Id.

138 Id.

139 Id.

5.4.1.1.5. *Role of Courts*

The court may be involved in matters relating to the medical treatment of a child, if the child is a ward of court.[140] The law requires prior judicial consent before any important or major step in the ward's life is taken.[141] The paramount criterion for exercise by the court of its inherent *parens patriae* jurisdiction is the 'welfare of the child' or in his or her 'best interests'.[142] The word welfare must be taken in its widest sense. Therefore, a wide range of ethical, social, moral, emotional and other aspects of well-being must be taken into account.[143] In relation to medical treatment, the court is bound to have regard to the ascertainable wishes and feelings of the child, considered in the light of his age and understanding.[144] Therefore, courts have assumed that *parens patriae* jurisdiction extends to protecting '*Gillick* competent' children where the child has made a decision which will seriously jeopardize the

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140 *Re S (Infants)* [1967] 1 WLR 396, 407. The mother of the child after getting divorced was living in California. In the wardship proceeding the custody was given to father and care and control was given to the mother. The mother applied for an order that her son should continue his education in California.

141 *Re D (A Minor) (Wardship: Sterilisation)* [1976] Fam 185,196. D, suffered from Sotos syndrome and was mentally retarded. A year earlier, she had reached puberty and her mother and paediatrician sought for sterilization. There was professional testimony that by age 18, D would understand the implications of a hysterectomy and be able to give informed consent. The court found that the proposed hysterectomy for non- therapeutic purposes was not medically necessary and refused to consent to D's sterilization. Hence, the Family Division of England's High Court of Justice decided to continue wardship of mentally retarded D and refused to consent to her sterilization.

142 *Re B (A Minor) (Wardship: Sterilisation)* [1988] AC 199,212. The House of Lords dismissed an appeal from a lower court decision authorizing the sterilization of a mentally retarded and epileptic 17-year-old girl. The judges ruled that in this instance, sterilization would be in the young woman's best interests and essential to her future well-being, and was not being requested for reasons of eugenics, public policy, or convenience.
Parens patriae is a protective jurisdiction which stems from the concept that the Crown has an inherent jurisdiction to do what is for the benefit of the incompetent. *Parens patriae* is a discretionary power invoked by the court to protect persons who, because of their legal disability, stand in need of protection. Best interest principle was developed in the 19th century. see for e.g., *Chapsky* v *Wood* 26 Kan.650(1881), where custody was awarded to a grandmother who had brought up her granddaughter, rather than to the biological father, as the court's paramount consideration was that of the girl's welfare, which would best be protected by the girl living with her grandmother. The principle of best interests is also found in a number of international instruments: Declaration of the Rights of the child 1959; Convention on the Rights of the Child 1989; Art.5(b)and16(1)(d) Convention on the Elimination of all forms of Discrimination against Women 1979; and art 5 Declaration on Social and Legal principles relating to Foster placement and Adoption nationally and internally, 1986.

143 Id. p.212.

144 *Re E (A Minor) (Wardship: Medical Treatment)* [1993] 1 FLR 386, 393. A 15 year old Jehovah's Witness refused blood transfusion and blood products. The parents put forward the argument that since he was close to 16 and his consent would be required, that they should respect his wishes. However, the court rejected this submission and overrode his decision not to consent to treatment.

child's health and survival.[145] While a mature minor can consent to medically recommended treatment, it is not clear whether and to what extent a '*Gillick* competent' child has the power to refuse health care, particularly when to do so may result in serious injury, illness or death?[146] In circumstances where a parent authorizes treatment against the wishes of a minor, the parental consent will be sufficient to authorize the treatment.[147] Some feel that a child who refuses treatment should demonstrate a greater degree of understanding than those who consent. The consequences of withholding consent to treatment are usually much more significant and potentially dangerous than simply giving consent. A more stringent test should therefore be applied when assessing a child's ability to refuse consent than when assessing competence to consent.[148] Further, elements of vulnerability and a need for protection attach to children by virtue of their youth. [149] They have not had the experiences nor formed the defenses which adults have and need protection against injury of whatever kind from whatever source.[150] Moreover, it would be a challenge to mature minors' interest in self-determination and autonomy if law allows them only to make those decisions about medical care that others would consider to be in his or her interests.[151] However, decisions by court shows that inherent powers of *parens patriae* jurisdiction could be invoked to override decisions made by children relating to medical treatment where it is in the children's best interests to do so.[152] Donaldson in *Re W*[153] stated:

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145 Pip Trowse, "Refusal Of Medical Treatment – A Child's Prerogative?", 10 *QUTLJJ* 191, p.197.

146 A lthough Lord Justice Balcombe in *Re W* admitted in logic there can be no difference between an ability to consent to treatment and an ability to refuse treatment.But in cases involving sterilisation or abortion the court's guidance should always be sought. If neither the young person nor any other person can give valid consent, the authority of the court should be sought, unless emergency treatment is required. See, Mike Shaw, Competence and consent to treatment in children and adolescents, *7 Advances in Psychiatric Treatment* 156 (2001).

147 *Gillick* v *West Norfolk &Wisbech Area Health Authority*, [1985]3 All ER 402. Lord Fraser, in *Gillick* stated that parental rights clearly do exist, and do not wholly disappear but dwindle as the young person's right strengthens with his or her growing maturity. See also, *Marion's case* (1991) 175 CLR 218.

148 Pearce, J, "Consent to treatment during childhood. The assessment of competence and avoidance of conflict", 165 *British Journal of Psychiatry* 713, (1994), p.713

149 *Re X (A Minor) (Wardship: Restriction of Publication)* [1975] 1 All ER 697, at p.700. A child's stepfather obtained an order preventing publication of a book about the child.

150 Id.

151 Manitoba Law Reform Commission, *Minors' Consent to Health Care* (Report No. 91) Winnipeg: The Commission, (1995) at p.5-7

152 See also,*Secretary, Department of Health and Community Services* v *JWB* (1992)175 CLR 218

153 *Re W (a Minor) (Medical Treatment : Court's Jurisdiction)* [1992] 4 All ER 627. pp.639-40 .

> no minor of whatever age has power by refusing consent to treatment to override a consent to treatment by someone who has parental responsibility for the minor and a fortiori a consent by the court. Nevertheless such a refusal is a very important consideration in making clinical judgements and for parents and the court in deciding whether themselves to give consent. Its importance increases with the age and maturity of the minor.

Thus, while the *Gillick* case remains a landmark decision in this area, subsequent cases have pointed out that the views of a person under the age of 16 cannot be equated with those of an 18 year old, who has actually reached the age of majority. In some cases, the question that arises is, as in *Gillick*, what role parents have, while in others the question of some other overriding consideration, such as the preservation of life, is involved. There is an argument that once it is established that a child is '*Gillick* competent' and, has capacity to make decisions relating to the proposed medical treatment, the child should be treated as a competent adult and entitled to make all medical decisions for which he or she has capacity, even if they involve high risk and complicated procedures.[154] One can argue that a '*Gillick* competent' child is no longer in need of protection, is not incompetent and, therefore, not within the category of subjects intended to attract the protective jurisdiction of the Crown known as *parens patriae*. This is reflected in the Canadian case of *Region 2 Hospital Corp* v *Walker*[155] , where the court specifically stated that its *parens patriae* jurisdiction did not extend to a mature minor. Generally little support for this argument can be found in case laws, which declares repeatedly that *parens patriae* extends to all children, '*Gillick* competent' or otherwise. The argument put forth by Pip Trowse is that 'a '*Gillick* competent' child is not an adult and, as such, should be entitled to the same protection afforded, by *parens patriae*, to those who are not '*Gillick* competent''.[156] Lord Donaldson in *Re W*[157] stated:

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154 L Bunny, 'The Capacity of Competent Minors to Consent and Refuse Medical Treatment' 5 *Journal of Law and Medicine* 53 (1997).

155 1994 NBR (2d) LEXIS 1127 [29]. In this case, the court noted that the *parens patriae* jurisdiction cannot be invoked to deprive competent mentally-ill patients of their treatment decisions, therefore it cannot apply to competent children. Likewise, *parens patriae* cannot be used to override the decision of an incompetent person who gave instructions about his or her treatment when competent. A 'mature minor' under Canadian law is one who is capable of understanding the nature and consequences of the proposed treatment.

156 Pip Trowse, "Refusal Of Medical Treatment – A Child's Prerogative?", 10 *QUTLJJ* 191, p. 200.

157 *Re W* (a minor)(medical treatment*)* [1992] 4 All ER 627,639.

> a minor of any age who is 'Gillick competent' in the context of particular treatment has a right to consent to that treatment, which again cannot be overridden by those with parental responsibility, but can be overridden by the court. Unlike the statutory right this common law right extends to the donation of blood or organs.

Further examination of case laws makes it clear that the courts have assumed *parens patriae* jurisdiction in protecting '*Gillick* competent' children where the child has made a decision which will seriously jeopardize the child's health and survival. Examples of decisions in support of this proposition are: The Court of Appeal in *Re W*[158] overrode the child's wish to undergo a particular form of treatment and held that the court has the power and the responsibility in appropriate cases to override the views of both the child and the parent in determining what is in the child's best interests.[159] The court accepted that it cannot lightly override the wishes of a '*Gillick* competent' child with respect to medical treatment unless it is in the child's best interests to do so. Lord Donaldson noted it would generally be in the child's best interests to follow his or her wishes, except where the child refuses medical treatment in circumstances which would probably result in death or severe permanent injury to the child.[160] However, the court has to ascertain the wishes of the competent child and will have to approach its decision with a strong predilection to give effect to the child's' wishes.[161] One has to note that the '*Gillick competence*' concerns the developmental progress of the child including the child's maturity and intelligence, and whether or not the child has reached a sufficient stage in his or her development and understanding to make a medical decision independently. But it is difficult to lay down the exact point at which the courts are entitled to interfere with the child's wishes. As Balcombe in *Re W*[162] said:

> it would not be helpful to try to define the point at which the court should be prepared to disregard the 16 or 17 year old child's wishes to refuse medical treatment. Every case must depend on its own facts. In general terms, however, the present state of the law is that an individual who has reached the age of 18 is free to do with his life what he wishes,

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158 Id.
159 Id at p.647
160 Id. p.643
161 Id. The case of a mentally incompetent child will present different considerations, although even there the child's wishes, if known, must be a very material factor.
162 *Re W* (a minor)(medical treatment) [1992] 4 All ER 627 at p. 648.

> but it is the duty of the court to ensure so far as it can that children survive to attain that age.

Similarly in *Re R*[163] the court stated that it can override the decisions of '*Gillick* competent' children in appropriate cases. While the court does so, it has to consider the whole of the medical background of the case as well as the doctor's opinion of the effect of its decision upon the patient's mental state.[164] These rulings have effectively made it impossible for a competent minor to refuse treatment and have led to controversy that after the decision in *Gillick*, there is a retreat to a paternalist approach towards young person's decision making capacities.[165] However, although the court readily states its power to override the decision of a '*Gillick* competent' child, a deep analysis of case laws shows that in most cases, doubt has been expressed in relation to the child's competence to make the decision.[166] In other cases, where the court has found the child is '*Gillick* competent,' legislation exists to support the court's decision.[167]

It is said that medical treatment for minors must be in their best interests but what happens if the child's parents and his or her doctor disagree about the treatment? It is generally seen that courts are not always keen to become involved in disputes between parents and doctors. For example, in *Glass* v *United Kingdom*[168] , the European Court of Human Right emphasized that the decision to impose treatment on the patient in defiance of his mother's objections gave rise to an

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163 *Re R* (A Minor) (Wardship : Medical Treatment) [1991] 4 All ER 177. This case concerned with a 15 year old girl who showed sufficient maturity and understanding at lucid intervals while suffering from mental illness. The court held that the gillick test is apt to a situation where the understanding and capacity of the child varies from day to day according to the effect of her illness.

164 Id, p.192

165 *Axon* v *Secretary of State for Health and Family Planning Association* [2006] QB 539, is an exception. The facts of the case resemble gillick case. A mother of five children brought a claim against the department of health for issuing guidelines which recognised the autonomy of young person's below 16 years to seek contraceptive advices and abortion services without the consent of the parent. The court confirmed the gillick test.

166 For e.g., in *Re W*, It is to be mentioned that one of the clinical manifestations of anorexia is that the patient will stress that he or she should not be cured unless and until he or she wishes to be cured. See also, *Re M (Child:Refusal of Medical Treatment)* [2000] 52 BMLR 124. The court in this case overrode the decision of a 15 year old girl who refused to provide consent for a heart transplant as she was found not to be 'Gillick' competent

167 See, for e.g., S.1(3)(a) of Children Act, 1989.

168 [2004] ECHR 103. Hospital administered high doses of diamorphine to severely ill and disabled child, against express wishes of his mother. Hospital did not seek court approval, claiming situation was an emergency, which by law is the only time doctors can over-ride consent by considering 'best interests' of the child, rather than asking a court to do it.

interference with his right to respect for his private life, and in particular his right to physical integrity.[169] Similarly in *Wyatt* v *Portsmouth NHS Trust*[170] the Court of Appeal highlighted the difficulty in ensuring court involvement in such issues as it is difficult to keep it appraised of changing circumstances in the patient's condition. Hence, it was considered that the courts are not the appropriate forum for decision-making about life-sustaining treatment for incompetent patients. But, it remains difficult for the family's views to prevail in court, because they lack the medical expertise which, in a test of best interests, remains the key, although not the only relevant factor.[171]

Accordingly, at present the responsibility for decision-making in matters of medical care is shared between the child, the parent and doctors exercising professional discretions, subject to overview by the State through welfare authorities and the courts. In consequence, a doctor dealing with a child may be left in doubt as to whether a child can give consent, whether anybody else's consent is necessary, and when and how to obtain it. Further, it is not clear to what extent a parent retains any right to make decision on behalf of a young person.

5.4.1.1.6 *Indian Position*

Interestingly in India, none of the judicial decisions has discussed the issue concerning the fixing of age limit for consent to medical treatment with regard to children. Also, unlike other countries, India does not have a separate legislation regarding age for consent to medical treatment for children. As a result we have to depend upon other statutes.[172] The primary statutory rule applying to consent and

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169 Id. para 70.

170 [2005] 1 WLR 3995. Charlotte Wyatt born prematurely suffered chronic respiratory, kidney problems and severe brain damage. A disagreement between her parents and doctors led the hospital to seek and obtain a court declaration that ventilation would not be in the patient's best interests.

171 Wicks, Elizabeth, *Human Rights and Healthcare*, Hart Publishing, Oregon (2007), p.111.

172 The age of majority in India is generally eighteen, except when a guardian of a minor's person or property has been appointed by the court, in which case it is twenty-one.. Section 3 of The Indian Majority Act, 1875 reads: "every person domiciled in India shall be deemed to have attained his majority when he shall have completed his age of eighteen years, and not before. In the case, however, of a minor of whose person or property or both a guardian has been appointed by a court, or of whose property the superintendence is assumed by a court of wards, before the minor has attained the age of eighteen years, when he has complete the age of 21 years".

competence is set out in s.13 and s.11 of Indian Contract Act respectively.[173] Also, s.88 and s.90 of Indian penal code can also be applied in this context.[174] Hence, a doctor taking consent for medical or surgical treatment from a person aged twelve years or more can be legally said to have taken a valid consent and cannot be held criminally liable on this account. In India, in practice we find that doctors generally prefer to take the consent of the parents or guardians before giving medical treatment. This is to avoid any legal complications as there is dearth of clear-cut laws in this area.

5.4.1.2. *Competency in Adult*

A patient must have the necessary capacity to consent to treatment. When considering the treatment of adults it is necessary to distinguish between two categories of patients. Firstly, there is the competent adult who has the necessary competency or capacity to decide which treatments they desire to receive. The second category of patient shall be those who are incapable of providing consent to treatment. The term 'incompetent' is widely used to describe these patients yet it is too narrow to be accurate. Though, 'incompetent' implies that the patient lacks

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[173] The relationship between a medical professional and his patient is a contract by parties competent to contract giving rise to contractual obligations. It should be noted that the Indian Contract Act is for conditions like marriages, financial agreements etc. and is not specific for the medical profession. This section defines consent as: 'two or more persons are said to consent when they agree upon the same thing in the same sense.' Consent is an agreement or in other words it is a contract between two people. Hence, S.10 of the contract Act requires that the parties must be *competent* to contract. *Competence* to contract is defined in S.11: 'every person is competent to contract who is of the age of majority according to law to which he is subject, and who is of sound mind, and is not disqualified from contracting by any law to which he is subject.' For consent to be valid it has to be free from coercion, undue influence, fraud, mistake etc.

[174] S.88 of IPC. **Act not intended to cause death, done by consent in good faith for person's benefit.**--Nothing, which is not intended to cause death, is an offence by reason of any harm which it may cause, or be intended by the doer to cause, or be known by the doer to be likely to cause, to any person for whose benefit it is done in good faith, and who has given a consent, whether express or implied to suffer that harm, or to take the risk of that harm.
Illustration
A, a surgeon, knowing that a particular operation is likely to cause the death of Z, who suffers under the painful complaint, but not intending to cause Z's death, and intending, in good faith, Z's benefit, performs that operation on Z, with Z's consent. A has committed no offence.
S.90 of IPC **Consent known to be given under fear or misconception.**
A consent is not such a consent as is intended by any section of this Code, if the consent is given by a person under fear of injury, or under a misconception of fact, and if the person doing the act knows, or has reason to believe, that the consent was given in consequence of such fear or misconception; or
Consent of child.
Consent of child.-unless the contrary appears from the context, if the consent is given by a person who is under twelve years of age.

capacity to understand, yet these patient's could have a potential to understand that is temporarily suspended due to one of a number of possible reasons, unconsciousness for example.

5.4.1.2.1. *The Competent Adult*

5.4.1.2.1.1 Test for Competency

In *Re T*[175] the Court of Appeal articulated a robust commitment to competent patient's autonomy when Lord Donaldson[176] stated:

> An adult patient who….suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered.

The presumption at law is that 'every adult is presumed to have…capacity, but it is a presumption which can be rebutted'.[177] In some jurisdictions, such as Queensland, [178]Western Australia[179]and England and Wales[180], modern legislation reinforces the common law rule by declaring that all adults are presumed to have capacity and by placing an evidentiary burden upon any person who asserts otherwise. Therefore, the

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[175] *Re T (Adult: Refusal of Medical Treatment)* [1992] 4 All ER 649. In this case a pregnant woman had been involved in a motor accident and was admitted to hospital after complaining of chest and shoulder pains. The patient had indicated on several occasions that she did not want a blood transfusion and signed a form of refusal. These refusals were alleged to have arisen in response to the influence of her mother, who was a practising Jehovah's Witness and present at times immediately before the patient had refused blood. The patient was not of that faith. After giving birth to a stillborn child the patient's condition worsened and she became unconscious. Her father and boyfriend sought judicial approval for the administration of blood products, and blood transfusions were authorized at trial on the basis that there was no binding refusal and that blood could be provided in her best interests.

[176] Id. pp. 652-3.

[177] Id. p.661. per Lord Donaldson.

[178] See, Guardianship and Administration Act, 2000 sch 1.
1. Presumption of capacity
An adult is presumed to have capacity for a matter.
2. Same human rights
(1) The right of all adults to the same basic human rights regardless of a particular adult's capacity must be recognized and taken into account.
(2) The importance of empowering an adult to exercise the adult's basic human rights must also be recognized and taken into account.

[179] Guardianship and Administration Act, 1990 (WA). s. 4(3) states: Every person shall be presumed to be capable of
(a) looking after his own health and safety;
(b) making reasonable judgments in respect of matters relating to his person;
(c) managing his own affairs; and
(d) making reasonable judgments in respect of matters relating to his estate,
until the contrary is proved to the satisfaction of the State Administrative Tribunal.

[180] Mental Capacity Act, 2005 (UK) s. 1(2) states: A person must be assumed to have capacity unless it is established that he lacks capacity.

outcome of an assessment of the patient's competency will determine whether or not the patient's decisions about their health are to be respected, or alternatively set aside, and some other approach taken.

The assessment of capacity is a difficult challenge as the concept is shrouded in uncertainty. This is because of the lack of consensus, not only about the nature of competency itself but also about the epistemic standards by which it ought to be assessed. As Milton D Green[181] argues:

> …no verbal formulation of a test can be made which will fit the standards laid down by the courts. So diverse is the phraseology of the tests by the courts in different jurisdictions, and even by various opinions within the same jurisdiction, that no single statement of a rule can be constructed.

According to Skegg[182], capacity to give legally effective consent depends upon the capacity to understand and come to a decision and the capacity to communicate that decision. The common law has developed a three-stage test to assess a patient's capacity or ability to understand in *Re C*[183]. This case concerned a paranoid schizophrenic who was suffering from gangrene in his foot. He refused consent to an amputation of foot even though the doctors told him that this was the only way to save his life. He sought a declaration from the court that his foot would not be amputated without his consent, arguing that he would rather die with two feet than live with one. The key issue for the court was whether C was mentally competent to refuse consent to the treatment despite his mental disorder. Thorpe J while deciding stated that a patient must be able to comprehend and retain the relevant information; believe it; and weigh it in the balance so as to arrive at a choice. This is known as the *Re C* test and it remains the authoritative common law test for capacity. The requirement of 'belief' to give a competent consent appears to throw great importance upon the clinical judgment of the doctor. If taken to its logical conclusion this would mean that a patient, who doubted the doctor's assertion that the procedure was the only viable option to prevent loss of life, would

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181 Green, MD, "Judicial Tests for Mental Incompetency", 6 *Missouri Law Review* 141 (1941), p. 147.

182 P.D.G. Skegg, *Law, Ethics and Medicine*, Clarendon Press, Oxford (1984), p.48.

183 *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 All ER 819.

be incompetent. [184] In another instance a patient may be able to fully understand the issues involved in undergoing a particular treatment, but if the patient is in such a panic that he or she is unable to process the knowledge to reach a decision then he or she will be considered as incompetent. For example, in *Bolton Hospitals NHS Trust* v *O*[185] a pregnant woman needed a Caesarean without which her life and that of her unborn would be in danger. She consented to the Caesarean section, but on four occasions when she was taken to the operating theatre, in a panic, she withdrew her consent. She was found to be incompetent on the basis that her refusal was not as a result of reasoned decision and the court declared it lawful to perform the operation.

In spite of its criticism, *Re C* test was unequivocally accepted in common law as well as in other jurisdictions. For example, in *Re JT (Adult: Refusal of Medical Treatment)* [186] , a patient was found to be competent despite mental disabilities and severe learning problems. In *Re Martin*[187], the United States adopted a similar approach when Michigan Court of Appeal held that the test for determining if a person has the requisite capacity to make a decision concerning the withholding or withdrawal of life-sustaining medical treatment is whether the person has sufficient mind to reasonably understand the condition, is capable of understanding the nature and effect of the treatment choices; is aware of the consequences associated with those choices; and is able to make an informed choice that is voluntary and not coerced. Some countries like Australia and Scotland have adopted a statutory test for competence.[188] These statutory tests provide limited guidance and merely repeat the three phase test proposed in *Re C.*[189]

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184 This is discussed further below.

185 [2003] 1 FLR 824.

186 [1998] 1 FLR 48.

187 504 NW-2d 917,924. (Mich App 1993). Martin was involved in an automobile accident in which he sustained serious injuries which left him dependent on his care takers. His legal guardian approached hospital for removal of life-sustaining medical treatment. Hospital though agreed with Mrs. Martin for removal of life sustaining treatment but declined to proceed without court authorization. She filed a petition. It was held that a surrogate decision maker for conscious patient who is not terminally ill or in a persistent vegetative state may be authorized to withhold life-sustaining treatment only if it is established by clear and convincing evidence that the person, while competent, previously expressed a desire to refuse life-sustaining medical treatment under the same or highly similar circumstances.

188 For example, Australian Guardianship and Administration Act, 1993; Adults with Incapacity Act 2000 in Scotland.

189 Stewart Cameron, Paul Beigler, "A Primer on the Law of Competence to Refuse Medical Treatment", 78 *Australian Law Journal* 325 (2004), p.328.

5.4.1.2.1.2 Refusal of Treatment

The corollary to the right to consent is the right to refuse medical treatment.[190] Competent adult patients are usually seen as being free to refuse medical treatment as they see fit. The courts are not concerned with the reasonableness of the patient's decision or his reasoning power nor is the law concerned with the rationality of the patient's decision or its basis unless that leads the court to conclude that the patient is suffering from a mental disability which deprives him of the ability to comprehend, retain, believe or weigh information.

A competent adult's right to refuse medical treatment emanates from an individual's right to privacy[191] and, in some cases, freedom of religion[192]. These rights are not absolute, notably where the refusal of treatment is likely to result in the patient's death. However, a growing number of courts have acknowledged the right of a competent adult to refuse medical treatment, even where the refusal is likely to result in the patient's death. For example, As Lord Staughton LJ in *Re T (Adult: Refusal of Treatment)*[193] stated:

> An adult whose mental capacity is unimpaired has the right to decide for herself whether she will or will not receive medical or surgical treatment, even in circumstances where she is likely or even certain to die in the absence of treatment.

The Court of Appeal in *Re B (Adult: Refusal of Medical Treatment)*[194] confirmed the common law right of a competent patient to refuse medical treatment, even though exercise of the right would result in the patient's own death. Further, it held that if a competent adult's refusal to treatment is not respected, health professionals and hospitals face the prospect of award of damages being made against them for unlawful trespass.

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190 Costello, "The Terminally Ill –the Law's Concerns", 21 *Ir Jur* 35 (1986), p.42.

191 *Superintendent of Belchertown State School* v *Saikewicz*, 370 N.E.2d 417, 426 (1977). The patient's right to privacy was described by the Massachusetts Supreme Judicial Court as follows:
> The constitutional right of privacy, as we conceive it, is an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life. The value of life as so perceived is lessened not by a decision to refuse treatment, but by the failure to allow a competent human being the right of choice.

192 See, *In re Osborne*, 294 A.2d 372 (D.C. 1972).

193 Re T (Adult: Refusal of Treatment) [1992] 4 All ER 649, 668.

194 [2002] 2 All ER 449.

The District Court of Appeal in Florida in *Satz* v *Perlmutter*[195] permitted the removal of an artificial life sustaining device from a competent adult based upon 'the constitutional right to privacy..... an expression of the sanctity of individual free choice and self-determination'.[196] In *Re Quinlan,* [197] Chief Justice Hughes argued that the 'State's interest weakens and the individual's right of privacy grows as the degree of bodily invasion increases and the prognosis dims, until the ultimate point when the individual's rights overcome the State's interest in preserving life'.[198] Thus, in *Re Quackenbush*[199], the New Jersey Superior Court acknowledged the right of a seventy two year old patient suffering from two gangrenous legs to refuse to have his legs amputated, even though the consequence almost certainly will be death. The court held that because the recommended treatment would entail an extensive bodily invasion, the State's interest in preserving life was outweighed by the patient's right.[200] In *Bouvia* v *Superior Court*[201], the court went a step ahead and decided that a competent patient has a right to refuse any medical treatment, including nourishment and hydration. The court argued that it would be 'incongruous, if not monstrous, for physicians to force a woman suffering from cerebral palsy and quadriplegia to live imprisoned…physically helpless and subject to the ignominy, embarrassment, humiliation and dehumanizing aspects created by her helplessness'.

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195 362 So. 2d 160, (Fla. Dist. Ct. App. 1978). Abe Perlmutter, seventy-three years old, was suffering from amyotrophic lateral sclerosis. Though fatal it does not affect mental functions. Perlmutter's 1978 request to have his respirator removed was approved by the Circuit Court of Broward County, Florida. The state appealed the case before the Florida District Court of Appeals, citing state's duty to preserve life and to prevent unlawful killing of a human being. The state also noted the hospital's and the doctors' fear of criminal prosecution and civil liability. The appellate court concluded that Perlmutter's right to refuse treatment overrode the state's interests, and found in Perlmutter's favour.

196 Id. p.426.

197 70 N.J. 10 (1976). In *Quinlan* a 22 year old girl was in a comatose condition on a respirator. The respirator, at the time, was essential to keep her alive. She was described by the testimony of doctors to be in a chronic persistent vegetative state which meant she had no cognitive functioning and no reasonable prospect of returning to a cognitive or sapient life. There was no medical procedure available to improve her condition.

198 Id. p.41.

199 383 A.2d 785 (1978).

200 Id. p.290.

201 *Bouvia* v *Superior Court* 179 Cal App 3d 1127 (1986). Elizabeth Bouvia was a severely disabled quadriplegic, almost totally immobile, and entirely dependent upon others for all her needs. In addition, she was in continual and severe pain. Mentally, however, she was intelligent and aware. She found it difficult to take food orally. It was, therefore, decided to feed her by nasogastric tube. She sought a court order that such treatment could be refused. Her right to self-determination was upheld by court and further stated that being competent she has the right to live remainder of her natural life in dignity and peace.

The court felt that the patient's decision to stop treatment and let nature take its course was not equivalent to taking active measures to commit suicide e.g., through an overdose of medication. It was recognized, however, that all decisions permitting cessation of medical treatment or life support procedures to some degree hasten the arrival of death. In part, at least, this was permitted because the quality of life during the time remaining in those cases had been terribly diminished.

A decision which appears irrational to a health care professional may make perfect sense in the context of the patient's religious and personal beliefs. In such cases, courts have upheld the right to refuse medical treatment,[202] even if the refusal is made on questionable grounds.[203] In *Re Osborne*[204], the District of Columbia Court of Appeals upheld the right of an adult Jehovah Witness to refuse blood transfusion on the basis that the patient had fully understood the consequences of his decision; released the hospital from liability; and provided for the future material well-being of his family.[205] To uphold integrity, and in particular the religious convictions of each person, it is essential that court's recognize the right of all patients with the capacity to make considered judgments, to refuse or request treatment and to make their own decisions regarding the kind of treatment they require, subject to other relevant moral considerations.[206] According to Andrew Grubb[207] there are two explanations of the law's position here.

> First, the law defers to religiously based decisions made by adults, though not those made on behalf of children, as a matter of social tolerance. Provided the person understands what is entailed in their decision, there is no reason for the law to deprive the individual of decision-making power. It would be an act of unjustified state interference to override decisions made on religious grounds. Secondly, and perhaps of more general importance for medical law,

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202 Lane v *Candura*, 376 N.E.2d 1232 (1978).

203 See, *In Re Quackenbush*, 383 A.2d 785,788(1978). Upholding a patient's right to refuse the amputation of gangrenous legs, despite indications that 'he hoped for a miracle and… is a coward about making decisions'.

204 294 A.2d 372 (D.C. 1972). The 34-year-old patient was admitted to the hospital with injuries and internal bleeding caused when a tree fell on him. As the need for whole blood became apparent, the patient refused to give his consent for the necessary transfusion. The patient's wife also refused the required consent. Both gave as reasons their religious beliefs which forbid infusion of whole blood into the body.

205 Id. at 373-374*;* see also *In re Lydia E. Hall Hospital*, 455 N.Y.S.2d 706 (1982).

206 Emily Jackson, *Medical Law, Text, Cases and Materials*, Oxford University Press, 2nd edn. (2010),p.216.

207 Andrew Grubb, *Principles of Medical Law*, 2nd edn, Oxford University Press (2004), p.166.

> such decisions do not stem from any mental disability or mental malfunctioning on the part of the patient.

A principle deeply ingrained in our culture is that of sanctity of life. Resolving conflict between the principles of autonomy and the sanctity of life can be difficult. The adult's right to refuse treatment extends, at least in theory, to cover situations where death is a likely, or even certain, consequence of that refusal. A skeptical analysis of refusal of treatment cases suggests that a refusal is unlikely to be respected where there is a 'socially valuable' life at risk.[208] The courts have upheld the individual's right to refuse, but these are where there is no life at risk, or the life at risk is arguably of limited 'social value', or where the individual's decision is seen as rational by the judge because continued life would be painful or pointless. For example, in *Re AK*[209], a patient with advanced motor neurone disease was held to have made a valid advance directive refusing further treatment after his ability to communicate was lost despite the fact that his competency could not be properly assessed. This was because without the ability to communicate or use his body in any way, his life was seen as lacking any further point. In the case of *Re B*[210], the claimant's refusal was upheld as competent because the judge arguably accepted that the life of a paraplegic was of little value if not valued by the individual herself. In *Re C*[211], a sixty-eight year old chronic paranoid schizophrenic, was held to be competent to refuse surgical amputation of a gangrenous leg, arguably, it was of little social concern whether or not his decision resulted in his death, which would have been of little, if any loss to the community. In both the *Secretary of State for the Home Department* v *Robb*[212] and *Re W*[213], the court held

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208 A.R.Maclean, 'Advance directives and the rocky waters of anticipatory decision making', 16 *Medical Law Review* 1 (2008), p.1.

209 *Re AK (Medical Treatment: Consent)* [2001] 1 FLR 129,133.

210 Re B (Consent to Treatment: Capacity) [2002] EWHC 49.

211 Re C (Adult: Refusal of Treatment) 1994 1 WLR 290.

212 *Secretary of State for the Home Department* v *Robb* [1995] 1 All ER 677. The respondent, a prison inmate with a personality disorder, went on hunger strike. The application concerned the question of whether it was lawful for his doctors and nurses to abstain from force feeding him in such circumstances.

213 *Re W* [2002] E.W.H.C. 901. This case concerned a prisoner who was suffering from a severe psychiatric disorder but who had been returned to the normal prison population after some treatment. To protest his conditions, the prisoner had cut open his shin and inserted objects and rubbed faeces into the wound, with the intention of causing blood poisoning. He made an advance directive to refuse all treatment. The prison authorities sought an order authorizing treatment. Butler-Sloss refused the application as there was no evidence of a lack of competence on the prisoner's part.

that the prisoners should be permitted to refuse life-sustaining treatment. This was because the prisoners could be seen simply as a drain on societal resources and, since there was no symbolic value in keeping them alive to endure their punishment, there was no social value in overriding their self-determining refusals of treatment. However, in *R* v *Collins, ex p Brady*[214], the court held that Ian Brady, the notorious Moors murderer who had gone on hunger strike as a protest at how he was being treated, lacked the competence to refuse forced feeding. It might be noted that just as in *Robb* and *W,* prisoners had little to offer to the community so did Brady who was simply a drain on resources. However, the decision to find Brady incompetent to refuse forced-feeding is not an anomaly, because his crime was so heinous that he could not be allowed to avoid his punishment, even through causing his own death. What these cases suggest is that in deciding whether to accept a refusal of treatment, the courts will assess the patient's competence on the basis of the outcome of the choice that he or she has made. This, of course, is contrary to the principle that treatment may be refused for irrational reasons or even no reason at all. What makes the outcome of choice irrational is that a worthwhile life will be lost that could otherwise have been preserved.

Another factor that courts sometimes consider is whether the patient's refusal infringes on the attending physician's standards of medical practice, i.e. whether it forces physicians to commit malpractice or to practice medicine in a manner which is inconsistent with their professional training and integrity.[215] In *United States* v *George*[216], the court stressed that a patient should not be able to dictate a course of treatment which required his physicians to ignore their own consciences and to commit virtual malpractice.[217] A court is most likely to consider the hospital and physician's countervailing interests where they are 'involuntary hosts' to a non-consenting patient i.e. where the patient comes to the hospital for emergency

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214 *R* v *Collins and Ashworth Hospital Authority ex p Brady* [2000] Lloyd's Rep Med 355.The case concerned with the convicted Moors Murderer, Ian Brady, who was on hunger strike and who, by way of judicial review, challenged the decision of the hospital to force feed him. The court found patient incompetent and held that the provisions of the Mental Health Act is justified in force feeding.

215 Martha Swartz, "The Patient Who Refuses Medical Treatment: A Dilemma for Hospitals and Physicians", *11 Am. J. L. and Med. 147* (1985), p.159.

216 239 F. Supp. 752 (D. Conn. 1985).

217 239 F. Supp. at 754.

treatment. In *John F. Kennedy Memorial Hospital* v *Heston,*[218] a twenty-two year old Jehovah's Witness was brought to a hospital emergency room after an automobile accident. The patient and her mother after the patient lost consciousness refused administration of blood transfusion for religious reasons. The hospital obtained a court-appointed guardian who directed physicians to administer the treatment. Upholding the guardian's decision, the New Jersey Supreme Court[219], described the hospital's dilemma as follows:

> Hospitals exist to aid the sick and the injured. The medical and nursing professions are consecrated to preserving life. That is their professional creed. To them, a failure to use a simple established procedure in the circumstances of this case would be malpractice; however the law may characterize that failure because of the patient's private convictions.

When hospital and staff are involuntarily hosts and their interests are pitted against the belief of the patient, it is reasonable to resolve the problem by permitting the hospital and its staff to pursue their functions according to their professional standards.[220] The court's reasoning implies that it might reach a different decision where a hospital had voluntarily agreed to treat a patient, having reason to know that the patient might refuse certain medical procedures.

The patient's privacy rights must be balanced against the state's interest in preserving life *per se*. For example, in *Bartling* v *Superior Court of the County of Los Angeles*[221], the court considered the significance of the state's interest in preserving life:

> If the right of the patient to self-determination is to have any meaning at all it must be paramount to the interests of the patient's hospital and doctors. The right of a competent adult patient to refuse

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218 58 N.J. 576, 279 A.2d 670 (1971).

219 Martha Swartz, "The Patient Who Refuses Medical Treatment: A Dilemma for Hospitals and Physicians", *11 Am. J. L. and Med. 147* (1985), p.160.

220 *Heston*, 279 A.2d 673. See also *Crouse Irving Memorial Hospital* v *Paddock*, 127 Misc. 2d 101, 485 N.Y.S.2d 443 (1985), where the court authorized a hospital to administer blood transfusions to a pregnant Jehovah's Witness not only to safeguard the fetus's health but to assure the treating physician necessary latitude in treating the patient. The court wrote: "When a patient puts her doctor in charge of a surgical procedure, she necessarily makes him responsible for the conduct of the operation. Every such grant of responsibility should be accomplished by authority sufficient to properly carry out the delegated responsibilities".

221 *Bartling*, 163 Cal. App. 3d 186.

> medical treatment is a constitutionally guaranteed right which must not be abridged.[222]

The fragility of the patient's self-determination in the face of preserving valued life is evident in the case of pregnant woman. Lord Donaldson in *Re T*[223] stated that the only possible qualification for exception to the right to refuse treatment is in a case in which the choice may lead to the death of a viable foetus. In practice there have been number of instances where an apparently autonomous pregnant woman has been denied the right to refuse treatment. In most cases this is achieved by finding the woman incompetent. For example, in *Rochdale Healthcare (NHS) Trust* v *C*[224], a pregnant woman was held to be incompetent when she refused a Caesarean section because her reasoning seemed irrational to the judge. This was despite the consultant obstetrician believing she was competent to decide and despite the fact that the judge had not actually met or spoken to the woman. Thorpe LJ[225] commented extra-judicially:

> Whatever emphasis legal principle may place upon adult autonomy with the consequent right to choose between treatments, at some level the judicial outcome will be influenced by the expert evidence as to which treatment affords the best chance of the happy announcement that both mother and baby are doing well.

In *Re S (Adult: Refusal of Treatment)*[226], Mrs.S wanted to refuse a caesarean section on religious grounds. Her competence was not in doubt. An emergency application was made, and after an ex parte hearing lasting less than two hours, Sir Stephen Brown granted a declaration that the operation would be lawful. *Re S* is almost certainly now of historical interest only. In two subsequent cases, the Court of Appeal has confirmed that pregnancy does not diminish the competent patient's right to refuse unwanted medical intervention. In *Re MB (An Adult: Medical Treatment)*[227], although MB was judged temporarily incompetent on the grounds of her needle phobia, Butler-Sloss LJ referred to *Re S* as 'a decision the correctness of which we must now call in doubt'. Instead, she was emphatic that:

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222 Id.
223 [1993] Fam 95.
224 *Rochdale Healthcare (NHS) Trust* v *C* [1997] 1 FCR 274.
225 Thorpe LJ, "The Caesarean Section debate", 27 *Family Law* 663 (1997), pp.663-4.
226 [1992] 4 All ER 671.
227 *Re MB (An Adult: Medical Treatment)* [1997] 38 BMLR 175.

> A competent woman who has the capacity to decide may, for religious reasons, other reasons, for rational or irrational reasons or for no reason at all, choose not to have medical intervention, even though the consequence may be the death or serious handicap of the child she bears, or her own death. [228]

A year later, in *St. George's NHS Trust* v *S*[229], the emergency caesarean section which had been performed upon S against her wishes was held to be a trespass. Judge LJ defended the pregnant woman's right to refuse treatment which could save her fetus's life, even if her decision might appear to be 'morally repugnant' and stated:

> while pregnancy increases the personal responsibilities of a woman it does not diminish her entitlement to decide whether or not to undergo medical treatment. Although human, and protected by the law in a number of different ways…, an unborn child is not a separate person from its mother. Its need for medical assistance does not prevail over her rights. She is entitled not to be forced to submit to an invasion of her body against her will, whether her own life or that of her unborn child depends on it. Her right is not reduced or diminished merely because her decision to exercise it may appear morally repugnant.

While the Court of Appeal's judgment in *St George's NHS Trust* v *S*[230] undoubtedly represents an especially robust assertion of the principle of patient autonomy, Thorpe LJ, writing extra-judicially, suggests that it may be easier for an appellate court to extol the primacy of autonomy, after the operation has already been successfully carried out, than it was for the judge who made the decision in the 'heat of the moment', when the surgery was immediately necessary in order to prevent loss of life. As Matthew Thorpe stated:[231]

> It is, perhaps, easier for an appellate court to discern principle than it is for a trial court to apply it in the face of judicial instinct, training, and emotion…It is simply unrealistic to suppose that the preservation of each life will not be a matter of equal concern to the Family Division judge surveying the medical dilemma. Whatever emphasis legal principle may place upon adult autonomy with the consequent right to choose between treatments, at some level the judicial outcome will be influenced by the expert evidence as to

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228 Id.
229 [1999] Fam 26.
230 [1998] 3 All ER 673.
231 Matthew Thorpe, "The Caesarean Section Debate", 27 *Family Law* 663 (1997), pp.663-4.

> which treatment affords the best chance of the happy announcement that both mother and baby are doing well.

Physicians and health care institutions are without clear answers to their concerns about civil and criminal liability for either complying with or opposing a competent adult's decision to refuse medical treatment. In the absence of a signed waiver, the treating physician potentially would be subject to malpractice claims for failing to administer necessary treatment. Even where a waiver has been signed, its validity might be subsequently challenged, on the basis of duress or mental incompetence. The physician might also be vulnerable to a variety of criminal homicide charges and to charges of aiding and abetting a suicide. Conversely, if the physician refuses to comply with the patient's wishes and administers unwanted treatment, he might be subject to claims of battery, malpractice and civil rights violations. Hence, in *John F. Kennedy Memorial Hospital, Inc.* v *Bludworth*[232], the Florida Supreme Court noted that living wills 'should be given great weight by the person or persons who substitute their judgment on behalf of the terminally ill incompetent'.[233] It further held that 'to be relieved of potential civil and criminal liability, guardians, consenting family members, physicians, hospitals, or their administrators need only act in good faith'.[234]

5.4.1.2.2. The Incompetent Adult

5.4.1.2.2.1 Defining Incompetency

The common law of contracts requires that two persons who wished to enter into a business agreement had to reach a 'meeting of the minds'.[235] If one of the parties lacked the necessary mental capability to reach such a meeting, the law would not recognize the contract. In *Dexter* v *Hall*[236] the U.S. Supreme Court commented on the effect that mental illness could have on the legality of a contract:

> The fundamental idea of a contract is that it requires the assent of two minds. But a lunatic, or person *non compos mentis*, has nothing which the law recognizes as a mind, and it would seem, therefore, upon principle, that he cannot make a contract which may have efficacy as such.

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232 *John F. Kennedy Memorial Hospital, Inc.* v *Bludworth,* 452 So. 2d 921, 926 (Fla. 1984).
233 Id.
234 Id.
235 Sandy Sanbar S *et al*, *Legal Medicine*, 6th edn., Mosby, Inc., Pennsylvania (2004), p.39.
236 *Dexter* v *Hall*, 82 U.S. 151 (1872).

Evidence of mental illness is not *per se* evidence of incompetency. Therefore, for the lunatic in *Dexter* to legally be considered incapable of executing a contract, he or she would have to demonstrate a present inability to meet the applicable standards for doing so as defined by law.[237]

Unlike in relation to children, the courts do not seem to take every opportunity to declare an adult patient as incompetent. According to Butler-Sloss LJ [238] incapacity occurs when a patient is unable to comprehend and retain information which is material to the decision, and weigh it in the balance of the process of arriving at the decision. For example, Thorpe J while applying the test in *Re C* concluded that though patient's general capacity is impaired by schizophrenia, it could not be established that he does not sufficiently understand the nature, purpose and effects of the treatment he refuses. This apparent reluctance to utilize all possible excuses to declare an adult patient incompetent would appear to indicate that courts are more interested in recognizing the autonomy and self-determination of an individual. Similarly, in *Re MB*[239] the Court of Appeal acknowledged that it would not be proper to find a patient incompetent merely because his decision was irrational, meaning one 'so outrageous in its defiance of logic or of accepted moral standards' that 'no sensible person who had applied his mind to the question to be decided could have arrived at it'. Similarly in *Re W (Adult: Refusal of Treatment)*[240] the court held that a patient would not be incompetent due to a lack of understanding as to the exact mechanism of his death should he refuse to consent. The opposite approach has been taken in relation to children, however, who must not only understand that they will die, but also how they will die and the suffering that will be felt by both the patient and their loved ones.[241]Accordingly, adults are perceived as having the right to make wrong decisions if they so wish. However, this freedom is generally only limited when it begins to impact upon the lives of other people.[242]

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237 Calamari J & Perillo J, *The Law of Contracts*, 4th edn., St. Paul, Minn., West Group (1998), 325.
238 *Re MB (Medical Treatment)* [1997] 2 FLR 426, 437.
239 *Re MB (Medical Treatment)* (1997) 38 BMLR 175 (CA), p.437 per Butler-Sloss LJ.
240 [2002] EWHC 901
241 *Re E (A Minor)(Wardship: Medical Treatment)* [1993] 1 FLR 386
242 Examples of such limits can be seen in the torts of negligence, occupier's liability and nuisance. For such torts it is necessary to show that the claimant has suffered some loss as a result of the actions of the defendant before liability will exist.

The Court of Appeal in *Re MB* accepted, however, that if the patient's irrational decision was based upon a misconception of reality stemming from a mental disorder, then the patient might lack the ability to comprehend or believe the information under the *Re C* test.[243] It is not necessary that always a patient's incompetence derives from a mental disability. A patient's ability to understand may be temporarily affected by external factors such as confusion, shock, fatigue, pain or medication.[244]Such factors may render a patient incapable of making a decision because the patient is unable to 'weigh' the information and make a choice. A patient's irrational fear of surgery[245] or a particular medical procedure[246] are not sufficient in themselves to make the patient incompetent in law to make a decision about their treatment. Only if the 'fear' acts on the patient's mind so as to 'paralyze the will and thus destroy the capacity to make a decision' will finding of incompetence be justified.[247] Religious beliefs which lead patient to refuse some or all medical treatment do not affect a patient's capacity, however irrational the belief may seem. A Jehovah's Witness who refuses a blood transfusion is not, by reason of the irrationality or otherwise of their beliefs, incompetent to make decisions about their medical treatment. Provided, they are able to understand what is involved i.e, comprehending, believing, and weighing the information their refusals will be legally binding upon the doctors.[248] Sometimes a patient's incapacity may be because of his inability to communicate a decision to the doctor. This may be either temporary or permanent, for example, the inability to communicate may arise due to the factor that the patient is physically disabled from communicating as he is in a persistent vegetative state. Provided all reasonable steps have been taken to communicate their decision, the law regards patients in this residual category of case as incompetent to make a treatment decision.[249]

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243 Id.
244 *Re T(Adult: Refusal of Treatment)* [1992] 4 All ER 649
245 See *Lane* v *Candura* (1978) 376 NE 2d 1232 (Mass App Ct).
246 *Re MB (Medical Treatment)* (1997) 38 BMLR 175 (CA), p.437 per Butler-Sloss LJ.
247 Id.
248 *Re T (Adult: Refusal of Treatment)* [1992] 4 All ER 649.
249 Andrew Grubb, *Principles of Medical Law*, 2nd edn, Oxford University Press (2004), p.170.

In India, the Law Commission Report on Medical Treatment to Terminally ill Patients[250] defines an 'incompetent patient' as being a minor or person of unsound mind or a person who is unable to understand the information relevant to an informed decision about him or her medical treatment; retain that information; use or weigh that information as part of the process of making his or her informed decision; make an informed decision because of impairment of or a disturbance in the functioning of his or her mind or brain; or communicate his or her informed decision as to the medical treatment. Accordingly, such patients are not competent to take 'informed decisions' about withholding or withdrawing medical treatment.[251] This definition more or less adopts the common law principle in determining incompetency in patients. If the requirements of the Mental Health Bill, 2013[252], introduced in the Rajya Sabha are satisfied then the incapacitated patient suffering from a mental condition will be treated, for that condition, in the same way as the competent adult with the same condition. It is in relation to the treatment of physical conditions that the approach to treatment may differ depending upon capacity. Thus, it emphasizes the principle laid down in *Dexter* v *Hall*[253] that mental illness is not *per se* evidence of incompetency.

5.4.1.2.2.2 Treating Incompetent patient

For the purpose of discussion, incompetent patients can be separated into two distinct groups. The first group covers those patients who are usually competent but are, for some reason or other, incapacitated at the time when the need for consent to be obtained arises. A typical example of such a patient would be a victim of a traffic accident who may be incompetent because of an accident and thereby unable to consent to treatment. Alternatively, the incompetency could be induced through the abuse of alcohol or drugs, or even due to excessive fear on the part of the patient. In relation to such patients the need for an emergency treatment can cause problems as proxy consent is not an option in relation to adults. The second category would

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250 Law Commission of India, 196th Report on Medical Treatment To Terminally Ill Patients (Protection Of Patients And Medical Practitioners), 2006, pp.4-5, http://lawcommissionofindia.nic.in/reports/rep196.pdf.

251 Id.

252 Mental Health Bill, 2013 was introduced in the Rajya Sabha in the month of September, 2013.

253 *Dexter* v *Hall*, 82 U.S. 151 (1872).

cover people who can be described as long-term incapacitated patients. For example, patients who are in a persistent vegetative state.

Applying the doctrine of necessity is a viable defence to any proceedings for non-consensual treatment where an unconscious patient is involved and there is no known objection to treatment. The treatment undertaken, however, must not be more extensive than is required by the exigencies of the situation.[254] A doctor cannot, therefore, take advantage of the unconsciousness, to perform procedures which are not essential for the patient's immediate survival or well-being. This was established in two well-known Canadian cases where the courts explored the distinction between procedures that are justified by necessity and those which are merely convenient, a distinction which is also applied by the common law.

In *Marshall* v *Curry*[255] the patient sought damages for battery against the surgeon who had removed a testicle in the course of an operation for hernia. According to the surgeon, the removal was essential to a successful operation and that, had he not done so, the health and life of the patient would have been imperiled because the testis was itself, diseased. Taking the view that the doctor had acted for the protection of the plaintiff's health and possibly his life, the court held that the removal of the testicle was necessary and that it would have been unreasonable to put the procedure off until a later date. By contrast, in *Murray* v *McMurchy*[256] , the plaintiff succeeded in an action for battery against a doctor who had sterilized her without her consent. In this case, the doctor had discovered during a caesarian section that the condition of the plaintiff's uterus would have made it hazardous for her to go through another pregnancy and he tied the fallopian tubes although there was no pressing need for the procedure to be undertaken. The court took the view that it would not have been unreasonable to postpone the sterilization until after consent had been obtained, in spite of the convenience of doing it on the spot. In *Williamson* v *East London and City Health Authority*[257] , an English case, a subcutaneous mastectomy was performed while the patient was unconscious during an operation to remove and replace a leaking breast implant was held to be merely

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254 Mason JK, McCall Smith RA, Laurie GT, *Law and Medical Ethics*, 6th edn, LexisNexis, UK (2002), p.312.
255 [1933] 3 DLR 260.
256 [1949] 2 DLR 442.
257 (1997) 41 BMLR 85.

convenient rather than necessary and the court was of view that consent should have been sought before the procedure was performed. Similarly, in *Tabor* v *Scobee*[258], an American decision, during the course of an authorized appendectomy on a female patient, the surgeon became aware of the patient's infected fallopian tubes and decided to remove the tubes at that point in the best interest of the patient. However, the court held that the patient's medical condition did not constitute an emergency because the patient would have had time to make an informed decision as to when she wished the procedure to be performed.

Looking at the question of whether the surgeon possessed the necessary authority to perform operation without express consent, MacFarlane J[259] in *Murray* v *McMurchy* stated:

> If it were necessary in the sense that it would be, in the circumstances, unreasonable to postpone the operation until a later date, I would say that… the surgeon would have that authority… There are times under circumstances of emergency when doctors must exercise their professional skill and ability without the consent that is required in the ordinary case.

Similarly, in *Malette* v *Shulman*[260], Robins, J.A. stated 'in an emergency the law sets aside the requirement of consent on the assumption that the patient, as a reasonable person, would want emergency aid to be rendered if she were capable of giving instructions'. In *Barnett* v *Bacharach*[261] the court held that in a medical emergency in which the patient lies unconscious on the operating table, the surgeon may lawfully carry out the duties of a physician in the best interest of the patient even if duties entail the performance of a procedure that was not originally contemplated. However, the treatment must be necessary to preserve the life, health

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258 *Tabor* v *Scobee*, 254 S.W. 2d 474(1951).

259 [1949] 2 DLR 442.

260 (1991), 67 D.L.R. (4th) 321 (Ont. C.A.).

261 *Barnett* v *Bacharach*, 34 A.2d 626 (1943). A patient who complained of abdominal pains was diagnosed with a tubal pregnancy. The patient consented to undergo surgery only for the removal of the ectopic pregnancy. On incision, however, the surgeon discovered that the patient did not have an ectopic pregnancy but the symptoms were instead from acute appendicitis. The surgeon determined that, in the best interest of the patient, the appendix should be removed, and an appendectomy was performed. Following the patient's uneventful recovery, the patient refused to pay for the surgical services provided because informed consent was not first obtained and thus the procedure was unauthorized. The court found that the surgeon acted properly because of the seriousness of the patient's condition.

and well-being of the patient.[262] It is important here to note an interesting observation made in *Dr. T.T. Thomas* v *Elisa*[263] by Thomas, J when he stated:

> The consent factor may be important very often in cases of selective operations, which may not be imminently necessary to save the patient's life. But there can be instances where a surgeon is not expected to say that 'I did not operate on him because, I did not get his consent'. Such cases very often include emergency operations where a doctor cannot wait for the consent of his patient or where the patient is not in a fit state of mind to give or not to give a conscious answer regarding consent. Even if he is in a fit condition to give a voluntary answer, the surgeon has a duty to inform him of the dangers ahead of the risks involved by going without an operation at the earliest time possible.

Medical emergencies that require blood transfusions frequently pose greater complications for physicians attempting to treat unconscious patients. This scenario is particularly difficult in cases in which the unconscious patient's family members indicate that the patient is opposed to blood transfusions for religious reasons and that the family will not provide the necessary consent. However, in *John F.Kennedy Memorial Hosp*. v *Heston*[264] it was held that if a life-saving blood transfusion is needed in an acute setting and the hospital is faced with an unconscious patient and a non-consenting family, the hospital should err on the side of saving the patient's life and simply perform the necessary procedure. The emergency exception, however, does not apply in situations where the health care provider is aware that the person expressed a wish, while capable, not to receive such treatment for example, where a

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[262] R. Freebairn, *et al*., "Informed consent and the incompetent adult patient in intensive care – a New Zealand perspective", 4 *Critical Care and Resuscitation* 61 (2002),p.62.

[263] AIR 1987 Ker 52. The patient was suffering from acute appendicitis and was advised surgery. Contrary to this, he was not operated upon by the doctor which led to his death. The doctor defended his action on the basis of the plea that the patient had declined to undergo the operation and therefore, in the absence of specific consent of the patient he was unable to take any action on his own. The court out rightly rejected this contention of the doctor and held that he was negligent in his conduct in as much as the patient had passed into a critical stage where the prime importance and the professional duty of a medical man is to save the life of the patient by doing all that is possible.

[264] 279 A. 2d 670 (1971). The appellant was an unmarried twenty-two year old female who had suffered a ruptured spleen in an automobile accident. Hospital personnel determined that an operation was required to save her life, necessarily including the transfusion of whole blood, but the patient a Jehovah's Witness, refused to give her consent to the blood transfusion. Death being imminent, a guardian with authority to consent to a blood transfusion was appointed by a court at the hospital's request and successful surgery was performed. Upon her recovery, the patient moved to have the court's order vacated. The Supreme Court of New Jersey affirmed the lower court's order.

Jehovah's Witness carries a card indicating that she does not wish to receive a blood transfusion.[265]

The legal foundations for the provision of treatment to incompetent adult patients in common law was set in *F* v *West Berkshire Health Authority*[266]. In this case the House of Lords applied the doctrine of necessity to a long-term incompetent patient. The patient in question was a 36-year-old woman suffering from severe mental disabilities, which meant she had a mental age of between four and five. Medical staff wanted to sterilize the patient as she had entered into a sexual relationship and it was thought that any resultant pregnancy would have a disastrous effect upon her condition. Lord Brandon[267] stated:

> In my opinion, the solution to the problem which the common law provides is that a doctor can lawfully operate on, or give treatment to, adult patients who are incapable, for one reason or another, of consenting to his doing so, provided that the operation or other treatment concerned is in their best interests.

Though this statement was made in relation to the treatment of all incapacitated patients it has already been shown that in relation to the short term incapacitated adult there needs to be some form of emergency. The 'doctrine of necessity' was confirmed when Lord Goff, in *F* v *West Berkshire Health Authority*[268] stated that in 'the case of a person of sound mind there would ordinarily have to be such an emergency before the doctrine of necessity would authorize an action which would otherwise be unlawful'. In relation to more long-term incompetents there is no such requirement. Lord Goff[269] made this clear when he stated that:

> In the case of a mentally disordered person, as in the case of a stroke victim, the permanent state of affairs calls for a wider range of care than may be requisite in an emergency which arises from accidental injury.

Lord Goff further explains the varying degrees to which the necessity principle may extend depending upon the duration of incompetence. He states that where a patient is temporarily rendered unconscious in an accident, doctors should

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265 *Malette* v *Shulman*(1991), 67 D.L.R. (4th) 321 (Ont. C.A.).pp. 328-29, per Robins, J.A.
266 *F* v *West Berkshire Health Authority* [1989] 2 All ER 545.
267 Id. p.551.
268 [1989] 2 All ER 545, 565.
269 Id. p.566.

'do no more than is reasonably required, in the best interests of the patient, before he recovers consciousness'.[270] Lord Goff also stated that where the state of affairs giving rise to the incapacity is permanent or semi-permanent there is no point in waiting for the patient to recover so that consent can be obtained.[271] The effect of this is that as the length of the incompetency increases it becomes easier to justify the treatment in question and the requirement that there must be an urgent need for treatment is reduced. Further, the courts were willing to extend this principle, however, to cover treatment which may not be strictly necessary but is instead merely beneficial to the patients. Lord Bridge[272] explained:

> if a rigid criterion of necessity were to be applied to determine what is and what is not lawful in the treatment of the unconscious and the incompetent, many of those unfortunate enough to be deprived of the capacity to make or communicate rational decisions by accident, illness or unsoundness of mind might be deprived of treatment which it would be entirely beneficial for them to receive.

Also, in *F* v *W. Berkshire HA*[273], the House of Lords held that law of battery can have no application, as it would bar incompetent patients from receiving care. As Elizabeth Wicks notes 'non-consensual treatment should not merely be regarded as a violation of the patient's right to be free of physical intrusions, but also the realization of his or her right to receive beneficial treatment.[274]

The application of the doctrine of necessity, and the increased importance of best interests, to long-term incompetents was reinforced in *Tameside and Glossop Acute Services Trust* v *CH.*[275] In this case Wall J stated that where a patient is incapable of making a rational decision about the suggested treatment the law must ensure that the patient's interests are protected.[276] It is important to note the shift

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270 Id.
271 Id. p.567 .
272 Id.
273 [1989] 2 All ER 545.
274 Elizabeth Wicks, *Human Rights and Healthcare*, Hart Publishing, Oregon (2007), p.93-4.
275 [1996] 1 FLR 762. The patient was a forty-one year old schizophrenic who had been detained under s.3, MHA Act, 1983 and then became pregnant. At thirty seven weeks gestation, it was felt that the foetus was in some difficulty and there was a need for an induced labour. A caesarean section was considered necessary if the foetus suffered further distress. There was some concern that although she consented to the induction she might withdraw her consent, and while this could have fatal consequences for the foetus, there was also concern for her mental wellbeing if the foetus was not delivered by Caesarean. An application was made to the court to authorise the performance of a caesarean section, using restraint if necessary.
276 Id. p. 768

away from referring to the patient's rights. Here we are not concerned with the right of the patient not to be treated without his consent. Rather we are looking at which medical treatment will provide the most benefit to the patient. While this may take into account what the patient desires it has already been shown, in relation to children, that this will not be determinative. As Wall J[277] stated 'where a patient could not communicate a decision then treatment would be lawful so long as it was necessary to save life or preserve or prevent deterioration of physical or mental health of the patient, and in the patient's best interests'.

From the above discussions it is clear that a doctor is justified by necessity in proceeding without the patient's consent if a condition is discovered in an unconscious patient for which treatment is necessary in the sense that it would be, in the circumstances, unreasonable to postpone the same to a later date. Postponement of treatment is, however, to be preferred if it is possible to wait until the patient is in a position to give consent.

A doctor's duty of care includes a duty to provide treatment which is in an incompetent patient's best interests. In *Herczegfalvy* v *Austria*[278] the European Court of Human Rights held that non-consensual treatment may amount to degrading treatment but will not do so if it is therapeutically necessary. The court further emphasized that it must 'satisfy itself that the medical necessity has been convincingly shown to exist'.[279] The increased focus upon best interests in relation to long-term incompetent patients appears to reflect the approach taken by the courts in relation to the treatment of minors. In support of this Butler-Sloss[280] has stated that:

> In considering the scope of best interests it seems to us that they have to be treated on similar principles to the welfare of the child since the court and the doctors are concerned with a person unable to make the necessary decision for himself.

In respect of incompetent adult patients, it has been established that the law does not permit proxy consent. If a patient is unable to provide consent to treatment, the doctors will provide treatment which is in the patient's best interests without having to obtain consent from any third party. Although in certain cases, including

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277 Id.
278 (1992) Series A, No 244, para 82.
279 Id.
280 *Re MB (Medical Treatment)* [1997] 2 FLR 426 .

sterilization and withdrawal of treatment, they should obtain a court declaration first. The *Quinlan*[281] case for the first time drew popular attention to the issue whether artificial life supports, could be withdrawn from a patient in a persistent vegetative state and how and by whom such a decision should be made. Under the practice prevailing at the time, the decision to withdraw a respirator was made by physicians exclusively and without family involvement.[282] This case, however, ushered in an era in which patients and families would exercise increased decision-making authority in areas previously considered the province of healthcare providers alone. Justice Hughes, while delivering the opinion of the New Jersey Supreme Court stated that 'the law, equity and justice must not themselves quail and be helpless in the face of modern technological marvels hitherto unthought-of'.[283] The Court strongly encouraged the development of hospital ethics committees, and expressed the hope that in future decisions could be made privately by families and providers, without involvement of courts.[284] While the case made no mention of living wills, following the publicity generated by the case, statutes authorizing 'living wills' began to be enacted in U.S.[285] In the United Kingdom, the whole edifice of legality of medical decision-making in respect of withdrawal of life sustaining treatment depends upon the court's categorization of the doctor's conduct in each particular case, the law is no more certain now than it was before the *Bland* case. The decision of the House of Lords in the *Bland* case, while specifically supportive of the concept of patient's autonomy, is implicitly mistrustful of the professional autonomy of medical personnel. Lord Lowery[286] articulated the unwillingness to relinquish judicial supervision of medical decision-making when he said that:

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281 355 A.2d 647 (N.J. 1976). This case presented new legal and ethical issues that came about as a result of technological advances in artificial life support that allowed individuals to be kept alive indefinitely through artificial means, sometimes in an unconscious state and without likelihood of regaining consciousness and or functional capacity. The patient's father sought to be appointed her guardian with the express power to authorize the discontinuance of the respirator. The hospital and treating physician opposed his action, contending that removal of the respirator would not conform to contemporary medical standards which allowed removal of a respirator only upon a determination of death under the criteria for brain death. The state intervened based on its interest in preserving life.

282 Id. p. 656

283 Id. p. 665.

284 Id. p. 669

285 Carol Stamatakis, "Beyond Advance Directives: Personal Autonomy And Their Right To Refuse Life-Sustaining Medical Treatment", 47 *N.H.B.J.* 20 (2007), p.21.

286 *Airedale NHS Trust* v *Bland* [1993] 2 WLR 316 at 378.

> in the absence of an application for a judicial declaration, the doctor who proposes the cessation of life-supporting care and treatment on the ground that their continuance would not be in the patient's best interests will have reached that conclusion himself and will be judge in his own cause unless and until his chosen course of action is challenged in criminal or civil proceedings.

Lord Browne-Wilkinson[287] acknowledged the failure of the decision to live up in practice to its stated goal of enabling doctors under the existing law, to make decisions in respect of withdrawal of treatment independently of the intervention of the court, when he said that:

> for the foreseeable future, doctors would be well advised in each case to apply to the court for a declaration as to the legality of any proposed discontinuance of life support where there has been no valid consent by or on behalf of the patient to such discontinuance

The approach of the House of Lords can be contrasted with that of Justice Thomas of the High Court of New Zealand in *Auckland Area Health Board* v *Attorney-General*[288], like in *Bland* case, doctors working in the intensive care unit of the Auckland Area Hospital applied for a declaration clarifying whether in law they would be guilty of culpable homicide under the New Zealand Crimes Act, if they withdrew the ventilator support system which maintained the breathing and heartbeat of a fifty-nine year old patient. Like in the House of Lords case, Mr.

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[287] Id.

[288] [1993] 1 NZLR 235. L was suffering from Guillain Barre syndrome. As a result, L's brain, though still living was entirely disengaged from his body. Mr. L did not suffer brain damage, though apparently, his consciousness was clouded, he was totally unable to move or communicate, and there was no prospect of recovery. The medical team of eight specialists who had examined Mr. L were unanimous that the ventilator support of the patient could not be medically justified. It was agreed that when the life-support system was withdrawn, death would be instantaneous and painless. The medical team had the support of Mr L's wife, and the approval of the hospital ethics committee. The doctors and the Area Health Board were sought a court declaration that they would not be guilty of culpable homicide under the Crimes Act 1961 if they withdrew a life support system. The court held that they would not be liable provided it was made in conformity with good medical practice.

Justice Thomas examined the parameters of the medical duty to continue treatment. The court's approach to this issue, however, was based upon different conceptual precepts of which one involved the medical duty of care based upon good practice, and the other the concept of a lawful excuse.[289] Unlike House of Lords, the New Zealand court's stated aim was to assist and encourage doctors to reach and administer these critical decisions without recourse to the Courts.[290]

Justice Thomas judgment exemplifies a balance between respect for the rights of patients, and the respect for autonomy of the ethical integrity of medicine and the medical professional judgment in regard to the diagnosis of the patient's condition, its prognosis and treatment. The judicial guidelines confine the decision-making process to the parties who are professionally or emotionally involved with the care of the incompetent patient, while excluding the necessity for determination

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289 Id. p. 254. When defining the ambit of medical duty of care, His Honour utilised the legal concept of 'necessaries of life', goods and services which are essential requirements of a person subject to incapacity. The provision of artificial life supports such as a ventilator may be regarded as a 'necessary of life' where it is required to prevent, cure or alleviate a disease that endangers the health or life of a patient. Where, however, the patient is surviving only by virtue of mechanical or biochemical means and is otherwise beyond recovery, the provision of such life-supports should not be legally construed as a necessary of life. To require the continuation of a life-support system when it serves no other purpose than to prolong his or her non-cognitive biological life is to act contrary to the primary purpose of medicine which is to preserve and promote health, and to alleviate suffering. In such circumstances, the continuation of the artificial means of life support may be lawful, but it does not make the termination of the support systems unlawful, providing the discontinuance accords with good medical practice.
Thomas J outlined the judicial view of what constitutes good medical practice. Within the doctor-patient relationship, doctors have a duty to treat patients in accordance with their own best clinical judgment, and should not be required to act contrary to this fundamental duty. In setting out these principles, Thomas J relied upon the judgment of Lord Donaldson in *Re J (a minor)* [1992] TLR 290. Since neither law nor medical ethics require doctors to treat the dying as if they were curable, a doctor is under no legal duty to prolong life or to defer death in cases where there is no reasonable possibility of the patient emerging from his or her unconscious condition to a cognitive, sapient state. See, *Auckland Area Health Board* v *Attorney-General* [1993] 1 NZLR 235, p. 251.
Consequently, the treating doctors have lawful excuse to discontinue life support systems when there is no medical or legal justification for continuing that form of medical assistance. The court in this case concluded that the cause of death, as a matter of law, will be attributed to the underlying condition of the patient rather than to medical conduct only when the doctors have followed the following relevant principles of good medical practice:
1. They have made a bona fide consultative decision as to what, in their judgment, is in the best interests of the patient.
2. The decision was made in accordance with the prevailing medical standards, practices, procedures and traditions which command general approval within medical profession.
3. The appropriate ethics committee has been consulted, and the proposed course of action was arrived at with informed concurrence of the patient's family and or guardians.
Thus, in New Zealand, doctors acting in accordance with these guidelines will be deemed to have acted with a lawful excuse and thus will not be liable to any criminal sanction.

290 Id. p.241.

by the courts, so long as proper procedures are followed. It is to be mentioned here that the court did not judicially examine the issue of withdrawal of life support systems from terminally ill incompetent patients.

A competent adult patient can provide an advance directive; a document which sets out what treatment a patient would or would not consent to in the event that he or she becomes incompetent.[291] Any valid advance refusal of treatment one made when the patient was competent and on the basis of adequate information about the implications of his or her choice is legally binding and must be respected where it is clearly applicable to the patient's present circumstances and where there is no reason to believe that the patient had changed his or her mind.[292] It necessarily follows from the above statement of legal principle that, in cases of advance refusals of life-sustaining medical treatment, the principle of autonomy prevails over that of sanctity of life. This position is reflected in and confirmed by the language used in end-of-life decisions. The supremacy afforded to the principle of autonomy in this context is perhaps most clearly articulated by Lord Goff in the landmark decision of *Airedale NHS Trust* v *Bland*[293]:

> First, it is established that the principle of self-determination requires that respect must be given to the wishes of the patient, so that if an adult patient of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes, even though they do not consider it to be in his best interests to do so ...To this extent, the principle of the sanctity of human life must yield to the principle of self-determination ... and, for present purposes perhaps more important, the doctor's duty to act in the best interests of his patient must likewise be qualified. ... Moreover the same principle applies where the patient's refusal to give his consent has been expressed at an

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[291] *R (Burke)* v *GMC* [2004] EWHC (Admin) 1879, para 44. Mr. Burke, was suffering from a progressive degenerative neurological condition and will eventually require artificial nutrition and hydration. He feared that on losing ability to communicate doctors might decide that his quality of life is such that they should withdraw artificial nutrition and hydration, considering this to be futile treatment, and this would cause him acute mental and physical suffering in contravention of his human right. He sought judicial review of the GMC guidance on the withdrawal of artificial nutrition and hydration. The court held that Mr. Burke was competent and that if he wished to continue to receive artificial nutrition and hydration in the circumstances envisaged it would be unlawful to discontinue it.

[292] See, e.g., *Re T (Adult: Refusal of Treatment)* [1993] Fam. 95; *Airedale NHS Trust* v *Bland* [1993] A.C. 789, 864 per Lord Goff; *Re C (Adult: Refusal of Treatment)* [1994] 1 W.L.R. 290.

[293] [1993] AC 789, 864.

> earlier date, before he became unconscious or otherwise incapable of communicating it ...

As part of the law's attempt to balance the principles of sanctity of life and autonomy, effect will only be given to an advance directive that is valid and applicable to the circumstances that have arisen. If the directive is not valid, or valid but not applicable to the situation that later arises, the appropriate treatment must be determined in another way. Where there is doubt about validity or applicability, the advance refusal will not be effective. In other words, any doubt is resolved in favor of the preservation of life.[294]

For advance directive to be valid, the adult must have had capacity at the time the advance directive was made, and must have been able to communicate the decision about treatment.[295] At common law, the meaning of 'capacity' is relatively settled and depends on the ability of an adult to function rationally.[296] Any undue influence or other vitiating factor that was exerted on adult at the time of signing may also affect the validity of the advance directive.[297] There are no formality requirements for the advance directive to be valid,[298] and it can be revoked by the adult at any time.[299] In addition to the requirements of capacity, the ability to communicate and the absence of vitiating factors, statements in some of the cases suggest that an advance directive will only be valid if it is based on sufficient knowledge or information. The suggestion is that the adult must be informed about treatment options before giving the directive, or at least has made the advance directive with knowledge of his or her illness and its likely progress.[300] A different approach was taken by the New South Wales Supreme Court in *Hunter and New England Area Health Service* v *A*,[301] a case involving a Jehovah's Witness who had completed a document refusing dialysis. While not citing any authority in support,

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294 See, for example, *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, p.112; *HE v A Hospital NHS Trust* [2003] 2 FLR 408,421.

295 *R (Burke)* v *General Medical Council* [2005] QB 424, 440. Kennedy and Grubb suggest that there is a further requirement for validity, that the adult have sufficient information on which to found a decision to refuse treatment: I. Kennedy and A. Grubb, *Medical Law*, 3rd edn (Butterworths: London, 2000) 2037-8. This view has also received some judicial support.

296 See, for example, *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 All ER 819.

297 For a consideration of when influence will be regarded as 'undue' and therefore vitiate validity, see comments of Staughton LJ in *Re T* [1992] 4 All ER 649, 669.

298 *HE* v *A Hospital NHS Trust* [2003] 2 FLR 408,417.

299 Id. p. 418.

300 *Re T (Adult: Refusal of Treatment)* [1993] Fam 95,115, per Donaldson MR

301 [2009] NSWSC 761.

McDougall J[302] rejected the notion that failure to provide adequate information could operate to vitiate a refusal of treatment and commented as follows:

> I do not accept the proposition that, in general, a competent adult's clearly expressed advance refusal of specified medical procedures or treatment should be held to be ineffective simply because, at the time of statement of the refusal, the person was not given adequate information as to the benefits of the procedure or treatment (should the circumstances making its administration desirable arise) and the dangers consequent upon refusal. As I have said, a valid refusal may be based upon religious, social or moral grounds, or indeed on no apparent rational grounds; and is entitled to respect ... regardless.

Even if an advance directive is valid, before it will govern treatment it must also be applicable to the adult's current circumstances. To be applicable, the issue is whether the adult intended the directive to govern the medical situation that later arose. This will require a consideration of the medical condition that later confronts the adult and the directive given previously, but also of whether the adult subsequently evinced an intention no longer to be bound by the directive.[303]

Another issue to be considered is whether the directive is revocable once the person becomes incapacitated. The law requires that, to be legally binding, the author must have the requisite capacity to make the decision. Since intentional revocation requires a decision, the person at that point must be legally competent. This means that the onset of incapacity should make the advance directive irrevocable even if the person subsequently changes his or her mind[304], which may require an advance directive to be implemented without the patient's co-operation.[305] As such, it may be contrary to the patient's interests at the time of implementation. Furthermore, it will also infringe whatever remnants of autonomy that the patient retains. It is understandable that this will be of concern to a caring and beneficent

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302 Id. p.28.

303 L. Willmott, B. White, M. Howard, "Refusing Advance Refusals: Advance Directives and Life-Sustaining Medical Treatment" 30 *Melbourne University Law Review* 211 (2006), pp. 220-1.

304 *Secretary of State for the Home Department* v *Robb* [1995] 2 W.L.R. 722. In the case of a prisoner with a sound mind who had determined to continue his hunger strike to the end, the court, applying the test as to capacity in Re T (1992) 4 All ER 649, granted an agreed declaration that it would be lawful to observe and abide by the refusal of the defendant to receive nutrition and lawful to abstain from providing hydration and nutrition whether by artificial means of otherwise for so long as the defendant retained the capacity to refuse the same.

305 Alasdair R. Maclean, "Advance Directives and the Rocky Waters", 16 *Med Law Rev* 1 (2008), p.10

profession. Where adult patients lack capacity to decide for themselves, an assessment of the benefits, burdens and risks, and the acceptability of proposed treatment must be made on their behalf by the doctor, taking account of their wishes, where they are known. Where a patient's wishes are not known it is the doctor's responsibility to decide what is in the patient's best interests. However, this cannot be done effectively without information about the patient which those close to the patient will be best placed to know.

Once a patient has been deemed incompetent, the issue arises as to who is authorized to make treatment decisions on the patient's behalf. [306]Some jurisdictions permit the patient's family and the treating physician to make treatment decisions without court intervention.[307] Others allow a court-appointed guardian to decide.[308] Finally, some jurisdictions require direct court approval in addition to or in lieu of the appointment of a guardian where the decision involves the withdrawal of life support.[309]

Courts have generally applied the 'substituted judgment' doctrine when determining the appropriate medical treatment for an incompetent patient.[310] This doctrine requires the surrogate to decide what the patient would have wanted had he been competent to make the decision.[311] In *Superintendent of Belchertown State School & another* v *Joseph Saikewicz*[312] court described substituted judgment doctrine as follows:

> The decision in cases such as this should be that which would be made by the incompetent person, if that person were competent, but taking into account the present and future incompetency of the individual as one of the factors which would necessarily enter into the decision-making process of the competent person.

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306 Martha Swartz, "The Patient Who Refuses Medical Treatment: A Dilemma for Hospitals and Physicians", 11 *Am. J. L. and Med.* 147 (1985), p. 169.

307 See for example, *John F. Kennedy Memorial Hospital* v *Bludworth*, 452 So. 2d 921 (Fla. 1984); *In re Hamlin*, 689 P.2d, at 1377.

308 See for e.g., *In re Quinlan*, 70 N.J. 10.

309 See for e.g., *Severns* v *Wilmington Medical Center, Inc.*, 42 A.2d 1334, 1347-50 (Del. 1980).

310 *See, e.g., Superintendent of Belchertown State School & another* v *Joseph Saikewicz*, 370 N.E.2d 417(1985)*; In re Hamlin,* 102 Wash. 2d 810; *In re Ingram,* 102 Wash. 2d 827.

311 *Superintendent of Belchertown State School & another* v *Joseph Saikewicz* , 370 N.E.2d 417(1985).

312 Id. p.431.

In applying this standard to the facts before it, the court approved the decision not to administer chemotherapy to a mentally retarded cancer patient since it agreed with the lower court that the patient would have suffered more from the administration of treatment than from the withholding of treatment.[313] The Supreme Court of Washington elaborated the 'substituted judgment' doctrine in *Re Ingram*[314], where it attempted to surmise whether a demented, delusional patient would have preferred surgery or radiation to treat cancer of the larynx. The court noted:

> The goal is not to do what most people would do, or what the court believes is the wise thing to do, but rather what this particular individual would do if she were competent and understood all circumstances, including her present and future competency.[315]

The court in *Ingram* went on to list the factors to be considered in ascertaining the patient's preference: the ward's prognosis if he chose no treatment, the prognosis if he chose one treatment over another,[316] the risk of adverse side effects from the proposed treatment, the ability of the ward to cooperate with post-treatment therapy, the ward's religious or moral views regarding the particular treatment or the dying process, and the wishes of family or friends if those wishes would influence the ward's decision.[317] The New Jersey Supreme Court in *In re Conroy*[318] set forth three different standards, depending on whether, before becoming incompetent, the patient had indicated preferences regarding treatment. First, where the patient has expressed a preference before becoming incompetent, there must be clear evidence that the patient would have refused treatment. This 'subjective test' can be satisfied by a document prepared by the patient before he became incompetent.[319] Second, where the patient has never clearly expressed his preference, there must be 'trustworthy evidence' that the patient would have refused treatment and the family or guardian must agree that the burden of continued life outweighs the benefits. This limited-objective test can be satisfied by reports of informal statements by the patient to

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313 Id.
314 102 Wash. 2d 827.
315 Id. p. 829.
316 Martha Swartz, "The Patient Who Refuses Medical Treatment: A Dilemma for Hospitals and Physicians", *11 Am. J. L. and Med.* 147 (1985), p.176.
317 102 Wash. 2d 827, 840.
318 486 A.2d 1209 (1985).
319 Id. p.1229.

family members or clergy.[320] Finally, where the patient has never indicated a preference, the court must find that the 'net burdens of the patient's life with the treatment clearly and markedly outweigh the benefits that the patient derives from life'.[321] In this 'pure-objective test', the key factor to be weighed is the level of pain and suffering, not the patient's personal worth.[322] In *In re Severns,* [323] the Delaware court considered the victim's membership in the Euthanasia Society and her previously expressed desire to die with dignity if she were ever unable to reason and care for herself as the result of an accident or illness.[324] Hence, the test is not objective in the sense that the court decides what is best for this particular patient or what most people would do or what a 'reasonable person' would do. It is a purely subjective test which focuses on the particular desires of the patient involved.

In *re Hamlin*[325], the Supreme Court of Washington considered the procedure for incompetents who had never been competent and had no families, as well as for incompetents who previously had been competent and who had families. Citing the language of the Washington guardianship statute, the court held that 'these decisions must be made on a case-by-case basis with particularized consideration of the best interests and rights of the specific individual'. [326] For example, in *Cruzan* v *Director, Mo. Dept. of Health*[327], the Missouri Supreme Court found that no person could exercise a choice on behalf of an incompetent individual in the absence of a living will or clear and convincing evidence of the patient's wishes. In this case the family failed to meet its burden of proof as they were relying on statements Ms. Cruzan had made to the effect that she would not want to live should she face life as a 'vegetable'. Hence, jurisdictions require exceptionally strong evidence of an incompetent individual's prior wishes in such circumstances.[328] In the absence of an advance directive, courts have required very specific evidence of a patient's previously expressed wish to forego life-sustaining treatment when the patient is not

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320 Id. p.1232.
321 Id.
322 Id.
323 *In re Severns,* 425 A.2d 156 (Del. Ch. 1980).
324 Id. p.161.
325 689 P.2d 1375.
326 Id.
327 497 U.S. 261.
328 Carol Stamatakis, "Beyond Advance Directives: Personal Autonomy And Their Right To Refuse Life-Sustaining Medical Treatment", *47 N.H.B.J. 20* (2007), p.23.

near death, in pain or in a chronic vegetative state. In *In re Michael Martin*[329], the Michigan Supreme Court reversed a lower court's order authorizing the withdrawal of artificial nutrition and hydration from a young man, paralyzed from an accident, who was incompetent but able to interact with others and his environment to a limited extent. Prior to his accident, he had made statements to his wife and co-workers that he would not want to live like a vegetable or be totally dependent on machines.[330] The Court found that the amount of weight accorded to prior oral statements depends on the remoteness, consistency, specificity and solemnity of the prior statement. In 2001, the California Supreme Court reached the same result in *Conservatorship of Wendland*[331], finding that for mentally incompetent patients who remain conscious, there must be clear and convincing evidence that the conservatee would desire to have his life-sustaining medical treatment terminated under the circumstances in which he now finds himself.[332] Comments about not wanting to be kept as a vegetable or on a respirator were found not sufficient evidence of the patient's wishes, where the patient was not terminally ill, in a persistent vegetative state or comatose.[333]

The Florida Supreme Court was one of the first courts to authorize family members to decide whether to terminate a patient's life support without court intervention. In *John F. Kennedy Memorial Hospital, Inc.* v *Bludworth*[334], the Florida Supreme Court reversed the trial court's order requiring the appointment of a guardian and court approval before the life support of a terminally ill, comatose patient could be terminated. The court held:

> The right of a patient, who is in an irreversibly comatose and essentially vegetative state to refuse extraordinarily life-sustaining measures, may be exercised either by his or her close family member or by a guardian of the person of the patient appointed by the court. If there are close family members such as the patient's spouse, adult children, or parents, who are willing to exercise this right on behalf of the patient, there is no requirement that a guardian

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329 *In re Martin*, 538 N.W.2d 399, pp.402-03

330 Id. p.411.Only when the patient's prior statements clearly illustrate a serious, well thought out, consistent decision to refuse treatment under these exact circum stances, or circumstances highly similar to the current situation, should treatment be refused or withdrawn.

331 28 P.3d 151,173 (Cal. 2001).

332 Id. p.153.

333 *San Juan-Torregosa et al.* v *Garcia et als.*, 80 S.W.3d 539, 541 (Tn.2002).

334 452 So. 2d 921 (Fla. 1984).

> be judicially appointed . . . . The decision to terminate artificial life support is a decision that normally should be made in the patient-doctor-family relationship.[335]

The Washington Supreme Court in *In re Hamlin*[336] held that where an incompetent patient has a family and all agree that the patient's best interest would be advanced by withdrawing the life sustaining treatment, no prior appointment of a guardian is necessary.[337] Accordingly, a guardian was required only where a patient had never been competent and had no family to assert his rights. Though, in *In re Colyer*[338], required the appointment of a guardian, but specifically held that judicial approval was not required in every decision to withdraw life sustaining treatment.[339] The court reserved for itself a role as overseer in the following situations: where family or physicians disagree about the patient's prognosis or the decision; where the patient has never been competent so that his wishes cannot be easily ascertained by the guardian; where wrongful motives or malpractice are suspected; or where the patient has no family member to act as guardian.[340] It was of the view that practice of applying to a court to confirm such decision would generally be inappropriate, not only because that would be gratuitous encroachment upon the medical profession's field of competence but because it would be impossibly cumbersome. Such a requirement is distinguishable from the judicial overview traditionally required in other matters such as the adjudication and commitment of mental incompetents. This is not to say that in the case of an otherwise 'justiciable controversy'[341] access to the

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335 Id. 926.

336 689 P.2d 1378.

337 Id. p.818.

338 99 Wash. 114, 660 P.2d 738 (1983). The court also required hospitals to establish 'prognosis boards' composed of at least three physicians. The function of the board is to determine that there is no reasonable medical probability that the patient will return to a sapient state.

339 Id. p.746.

340 Id. p.750.

341 A 'justiciable controversy' might occur when close relatives disagree about the manner in which to proceed. For example, in *Petition of Nemser*, 51 Misc. 2d 616, 273 N.Y.S.2d 624 (1966). Two children of an 80 year old woman applied to be appointed guardian to consent to the amputation of their mother's foot. Because the third child, a physician, challenged the petition, a court order was necessary to resolve the controversy. Similarly, the court should be consulted if a patient's closest relative demands treatment which is different from that originally requested by the patient. For example, in *Collins* v *Davis*, 44 Misc. 2d 622, 254 N.Y.S.2d 666 (1964), the patient initially sought treatment, but subsequently became incompetent. When his wife refused to consent to life-saving treatment on her husband's behalf, the hospital appropriately requested the court to resolve the controversy.

courts would be foreclosed; mention is made rather of a general practice and procedure.[342]

The following quote by Gedge, E, *et al.*,[343] captures the difficult relationship between medical and ethical challenges in the health care setting.

> Patient's unequivocal right to refuse medical treatment is well established and is ethically justified by the principle of autonomy, according to which people have a right to self-governance, to act freely in accordance with a self-chosen plan. Control over our body has been taken to be central to the interpretation of autonomy. In the context of end-of-life care, the right to refuse treatment places a recognized limit on interventions by medical officers, who must respect refusals even against their best clinical judgment and even if a patient's life is at risk as a result.

Just as respect for patient autonomy cannot be interpreted as an entitlement to every requested medical intervention, it does mean a medical officer's obligation to secure patient consent to the withholding or withdrawal of futile or inappropriate treatment which is not clinically indicated. Court process, especially in relation to such emotionally charged issue as termination of life, is always a harrowing experience both for the medical personnel and the family of the person involved. Therefore, the problem of consent on behalf of the competent adult who subsequently becomes incompetent might be resolved, in part, by the statutes. However, even where a patient has previously executed a 'living will', restrictions contained in many of the statutes might require prognosis boards or ethics committees, attending physicians and, in some cases, the courts, to continue to participate in these decisions. The above discussion shows that as far as incompetent patients are concerned the courts are largely undecided as to whether it was desirable to enlarge its role in this area; consequently, any mandatory procedure should be approved by statutes.

In India, there is no clear enunciation of law pertaining to the advance directive made by incompetent patients. Also, the doctrine of 'substituted judgement' is cautiously applied by the court. In *Aruna Ramachandra Shanbaug* v

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342 *Quinlan*, 355 A.2d pp. 668-69.

343 Gedge, E., Giacomini, M., Cook, D., "Withholding and withdrawing life support in critical care settings: ethical issues concerning consent", 33 *J. Med. Ethics* 215 (2007), p.215.

Union of India[344], the Supreme Court of India held that even if a decision is taken by the near relatives or doctors or next friend to withdraw life support, such a decision requires approval from the concerned High Court.[345] According to the court, if it is solely left to the patient's relatives or to the doctors or next friend to decide whether to withdraw the life support of an incompetent person there is always a risk that this may be misused by some unscrupulous persons who wish to inherit or otherwise grab the property of the patient. Recently, a petition filed by NGO Common Cause has called for clear enunciation of law with regard to execution of 'living wills'.[346] While acknowledging the necessity to adopt a suitable procedure by governments to ensure that terminally ill persons should be permitted to execute living will, the Supreme Court has referred *Aruna Ramachandra Shanbaug's* case to a five-judge constitution bench.

5.4.2. Information

In the past, doctors were under no obligation to provide information to their patients about their prognoses, or advantages and disadvantages of different treatments. On the contrary, it was up to the doctor to exercise his skill and care in deciding the best course of action for a patient.[347] This may be because a person who is ill or injured is considered highly vulnerable to others, and highly dependent on

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344 2011 (4) SCC 454. The staff of the KEM hospital have looked after Aruna for thirty-seven years, after she was abandoned by her family. The court felt that the Dean of the KEM Hospital, representing the staff of hospital, is an appropriate surrogate. If the doctors treating Aruna Shanbaug and the Dean of the KEM Hospital, together acting in the best interest of the patient, feel that life sustaining treatments should continue, their decision should be respected. While the SC dismissed Pinki Virani's petetion on the ground that she had no *locus standi* on this case, it appreciated the noble sentiments behind Pinki's plea. The court considered three important issues. First, If a person who is in a permanent vegetative state (PVS), should withholding or withdrawal of life sustaining therapies be permissible or not unlawful ? Second, if the patient has previously expressed a wish not to have life-sustaining treatments in case of futile care or a PVS, should his or her wishes be respected when the situation arises? Third, in case a person has not previously expressed such a wish, if his family or next of kin makes a request to withhold or withdraw futile life-sustaining treatments, should their wishes be respected?

345 Id. para138.When such an application is filed the Chief Justice of the High Court should forthwith constitute a Bench of at least two Judges who should decide to grant approval or not. Before doing so the Bench should seek the opinion of a committee of three reputed doctors to be nominated by the Bench after consulting such medical authorities/medical practitioners as it may deem fit. Preferably one of the three doctors should be a neurologist, one should be a psychiatrist, and the third a physician. For this purpose a panel of doctors in every city may be prepared by the High Court in consultation with the State Government or Union Territory and their fees for this purpose may be fixed.

346 *Passive euthanasia needs comprehensive guidelines: SC*, The Times of India, Wednesday, February 26, 2014.

347 Emily Jackson, *Medical Law, Text, Cases and Materials*, 2nd edn., Oxford University Press (2010),p.167.

their action and competence.[348] It was the general perception among doctors that a poor prognosis, possible side-effects, or availability of alternative treatments would be likely to cause distress and confusion, and hence might jeopardize the possibility of recovery.[349] Moreover, it would not have occurred to doctors that patients too might have the ability or the judgment to make choices about their medical care.[350]The Hippocratic Oath[351] itself assumes that treatment decisions are for the doctor alone:

> I swear by Apollo and Aesculapius that I will follow that system of regimen which according to my ability and judgement I consider for the benefit of my patients…
>
> Perform these duties calmly and adroitly, concealing most things from the patient while you are attending to him. Give necessary orders with cheerfulness and serenity, turning his attention away from what is being done to him; sometimes reprove sharply and emphatically, and sometimes comfort with solicitude and attention, revealing nothing of the patient's future or present condition.

In the medieval period the intimate relationship between physicians, patients and God made questioning of doctors' practices difficult. It was a belief that doctors were appointed by God hence; they would disdain explaining themselves and their practices.[352] The post-Medieval history of the content of conversations between physicians and their patients might be characterized as a triumph of hope over truth. The English physician Thomas Percival was the chief proponent of this ethic. Percival believed that physician should be 'minister of hope and comfort' who shapes conversations with patients to counteract the depressing influence of the patient's maladies. [353] Percival citing Pufendorf in support of his position, in *Law of Nature and Nations*, asserted that one need not speak truthfully when doing so would injure the listener.[354] This is particularly so when comforting the afflicted.[355]

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348 Onora O'Neill, *Autonomy and Trust in Bioethics*, Cambridge University Press, Cambridge (2002), p.38.

349 Id. p.168.

350 Id. p.167.

351 Hippocrates, "Oath of Hippocrates" in *1 Hippocrates*, WHS Jones trans. (1962), p.299.

352 Jay Katz, *The Silent World Of Doctor And Patient*, John Hopkins University Press, USA (1984).p. 9.

353 Thomas Percival, Medical Ethics: A Code Of Institutes And Precepts Adapted To The Professional Conduct of Physicians And Surgeons, Edmund D. Pellegrino ed. (1985), pp.31-2.

354 Id.

355 Id. p.162

The principle that the doctor should decide which treatment the patient should receive has gradually been replaced by a partnership model of decision-making during the twentieth century, in which both the doctor and the patient have specialist knowledge which must be shared in order to ensure that the patient makes the best possible decision.[356] This was a result of the growing importance of the principle of patient autonomy.

During World War II, thousands of concentration camp prisoners were used as human guinea pigs against their will in experiments that were typically excruciatingly painful and generally led to death or permanent disfigurement by German physicians and scientists under the Hitler regime.[357] Immediate aftermath of war, a series of military tribunals were convened to judge the guilt of those accused of atrocities.[358] Following the decision in *United States of America* v *Karl Brandt et al*[359], the war crimes tribunal that convicted several of the notorious 'Nazi Doctors' produced what has since become known as the Nuremberg Code, widely regarded as the first international code of human experimentation ethics.[360] The first and best known provision of the Nuremberg Code stated:

> The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision…

The Code contained ten ethical standards to which doctors should adhere to when conducting research involving human subjects. The main ethical standard clearly addressed in the Code was the voluntary consent of the involved human subject in

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356 Under the partnership model the doctor is a source of information and expert advice, but the ultimate decision is for the patient.

357 Vanderpool, Harold Y, *The Ethics of Research Involving Human Subjects: Facing the 21st Century*, University Publishing Group: Frederick, MD (1996), pp. 431-2.

358 Len Doyal, Jeffrey S Tobias, *Informed Consent in Medical Research*, BMJ Books: London (2000), p.7.

359 *United States of America* v *Karl Brandt et al* US Military Tribunal Nuremberg, Judgement of 19 July 1947.

360 Vanderpool, Harold Y, *The Ethics of Research Involving Human Subjects: Facing the 21st Century*, University Publishing Group: Frederick, MD (1996), pp. 431-2.

the research which was described by the Code as being absolute.[361] The document goes on to detail the informational and other elements inherent in the notion of voluntary consent, established nine additional principles of ethical research.[362] Since then, informed consent has enjoyed growing widespread consensus and gained broader scope over the time period. Well before professional associations worldwide endorsed it within their deontological guidelines and codes of ethics, their most representative international institution, the World Medical Association, had proclaimed the right of competent patients to accept or refuse treatment in its 1949 International Code of Medical Ethics. The WMA later upheld the rule of informed consent in the Declaration on the Rights of the Patient. Although not binding these acts predated domestic laws regulating biomedical issues and served as reference codes of conduct for biomedical practice and research worldwide. In the 1960s, further efforts were made to clarify and codify the concept of informed consent. As a result, in 1964, the World Medical Association issued Declaration of Helsinki, which asserted the requirement of informed consent for all non-therapeutic research, i.e., research for purposes of investigation.[363] In contrast, in the case of therapeutic research or research conducted by a clinician investigating possible benefits of a treatment for a sick patient, the declaration said that consent should be sought 'consistent with patient psychology', to be determined by the physician. Most recently, the International Ethical Guidelines adopted by the Council for

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361 The Code begins with the first principle which became the focus of much attention:
The voluntary consent of the human subject is absolutely essential.
This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, over-reaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision. This latter element requires that before the acceptance of an affirmative decision by the experimental subject there should be made known to him the nature, duration, and purpose of the experiment; the method and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and the effects upon his health or person which may possibly come from his participation in the experiment.
The duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs or engages in the experiment. It is a personal duty and responsibility which may not be delegated to another with impunity.

362 See, generally, The Nuremberg Code, viewed 7th May 2013, viewed 12 the Feb 2013, http://www.state.nj.us/health/irb/documents/nuremburg_code.pdf.

363 *World Medical Association Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects*, adopted by the 18th World Medical Association (WMA) General Assembly, Helsinki, Finland, June 1964; amended most recently by the 52nd WMA General Assembly, Edinburgh, Scotland, October 2000.

International Organizations of Medical Sciences (CIOMS) reasserted the primacy of informed consent.[364]

5.4.2.1. *Origin of Informed Consent*

The doctrine of informed consent developed out of strong judicial deference to individual autonomy, reflecting a prevalent belief that an individual has a right to be free from nonconsensual interference with his or her person, and a basic moral principle that it is wrong to force another to act against his or her will.[365] Today, this doctrine is globally recognized as dictating the *conditio sine qua non* for clinical practice and biomedical research.[366] Its significance in international biolaw is reflected by the fact that virtually all international agreements and declarations on ethical and legal standards in medicine and biomedical research endorse the basic rule of informed consent.[367]

The concept of informed consent arguably first appeared in a judicial opinion in 1767 in the English decision of *Slater* v *Baker and Stapelton*[368] where the court reasoned that 'it is reasonable that a patient should be told what is about to be done to him, that he may take courage and put himself in such a situation as to enable him to undergo the operation'. The principle was further articulated in the medical context by Justice Cardozo in *Schloendorff* v *Society of New York Hospital*[369] :

> Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages.

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364 Council for International Organizations of Medical Sciences [CIOMS], *International Ethical Guidelines for Biomedical Research Involving Human Subjects*. Geneva, Switzerland, CIOMS, 1993. Viewed 13th Feb 2013, http://www.cioms.ch/frame_1993_texts_of_guidelines.htm.

365 Barry R Furrow, Thomas L Greaney, Sandra H Johnson, Timothy Stoltzfus Jost, Robert L Schwartz, *Health Law*, 2nd edn, West Group, St. Paul Minn (2000), p.310.

366 Stefania Negri, *Self-Determination, Dignity and End of Life Care Regulating Advance Directives in International and Comparative Perspective*, Martinus Nijhoff Publishers, The Netherlands (, p.25.

367 Regine Kollek, "Article 6: Consent", in HAMJ ten Have and MS Jean (eds.), *The UNESCO Universal Declaration on Bioethics and Human Rights. Background, principles and application*, Paris (2009), p.124.

368 2 Wils KB 359, 362. A surgeon without the patient's consent, refractured patient's leg and placed it in an experimental apparatus to stretch and strengthen it during healing. The court found that it was the normal practice of surgeons to seek consent before refracturing a patient's leg, especially when surgical procedures were carried out without anesthesia, it was important for patients to prepare themselves for the infliction of excruciating pain. Hence, it was held that there had been an improper breach of professional conduct.

369 105 N.E. 92 (1914),93.

During the next four decades, most courts followed Cardozo's lead in grounding actions regarding the lack of patient consent in trespass or assault. These courts focused on whether patients had consented to the challenged physician actions. Few, however, addressed what information, if any, the physician should provide the patient to ensure that the consent was informed.[370] As Jay Katz has put it, 'these decisions neither invited nor required a sophisticated examination of the relationship between disclosure and consent, on the one hand, and self-determination, on the other'.[371] In *Salgo* v *University Board of Trustees*[372], the Californian Court of Appeal was careful, not to measure the needed disclosure solely according to the patient's wishes. While coining the phrase 'informed consent' for the first time the court called for balancing patient's wishes with physician's judgment.[373] The court held that 'a physician violates his duty to his patient…if he withholds any facts which are necessary to form the basis of an intelligent consent'.[374]This is clear from the following argument by Bray, J[375]**:**

> The physician must place the welfare of his patient above all else and this very fact places him in a position in which he sometimes must choose between two alternative courses of action. One is to explain to the patient every risk attendant upon any surgical procedure or operation, no matter how remote; this may well result in alarming a patient who is already unduly apprehensive and who may as a result refuse to undertake surgery in which there is in fact minimal risk; it may also result in actually increasing the risks by reason of the physiological results of the apprehension itself. The other is to recognize that each patient presents a separate problem, that the patient's mental and emotional condition is important and in certain cases may be crucial, and that in discussing the element of risk a certain amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent.

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370 W. John Thomas, **"**Informed Consent**,** The Placebo Effect, And The Revenge Of Thomas Percival", 22 *J. Legal Med*.313 (2010).

371 Jay Katz, *The Silent World Of Doctor And Patient***,** John Hopkins University Press, USA (1984).p.50.

372 317 P.2d 170 (Cal. Ct App.1957). In *Salgo*, the patient suffered injuries during a diagnostic procedure. The patient alleged that his physician had not provided him with any information about the procedure, including the risks associated with it.

373 Berg, Jessica W, et al, *Informed Consent: Legal Theory and Clinical Practice*, Oxford University Press, Oxford (2001), p.44.

374 *Salgo* v *University Board of Trustees* 317 P.2d 170 (Cal. Ct App.1957).

375 Id.p.181.

In doing so, the court based all medical judgments on the physician's determination of the best course of conduct for ensuring the patient's ultimate recovery. It further laid down that even a written consent is ineffective if the patient failed to understand material information about the procedure to be undergone. In *McKinney* v *Nash*[376] , the court defined material information in the following terms:

> Material information is that which the physician knows or should know would be regarded as significant by a reasonable person in the patient's position when deciding to accept or reject the recommended medical procedure. To be material, a fact must also be one which is not commonly appreciated. If the physician knows or should know of a patient's unique concerns or lack of familiarity with medical procedures, this may expand the scope of required disclosure.

In the two decades following *Salgo's* invocation of the phrase informed consent**,** the courts of all states embraced the informed consent doctrine.

According to Katz[377], the judicial development of informed consent into a distinct doctrine can be roughly divided into three periods. During the first period, up to the mid-twentieth century, courts built upon the law of battery and required little more than disclosure by doctors of their proposed treatment. The second period saw an emerging judicial belief that doctors should disclose the alternatives to a proposed treatment and their risks, as well as of risks of the proposed treatment itself. The third period, from 1972 to the present, has seen legislative retrenchment and judicial sluggishness.

5.4.2.2. *Legal Protection for Patients in Information disclosure*

In this part we discuss what legal claim is appropriate when consent has not been properly informed. The two main issues which are considered here is whether the lack of adequate information vitiates the patient's consent altogether and hence whether a claim would lie in battery? or is the provision of information a part of the doctor's ordinary duty of care, meaning that a failure to offer adequate information might ground an action in negligence.

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376 *McKinney* v *Nash*, 120 Cal.App.3d 428.

377 Jay Katz, "The Silent World of Doctor and Patient" in Barry R Furrow, Thomas L Greaney, Sandra H Johnson, Timothy Stoltzfus Jost, Robert L Schwartz, *Health Law*, 2nd edn, West Group, St. Paul Minn (2000), pp.310-11.

5.4.2.2.1. *Battery*

In order to give a valid legal consent or refusal to treatment, a patient must understand adequately what is involved in the procedure. Hence, patient's consent must be 'real'.[378] For consent to be 'real', the patient must understand in broad terms the 'nature' of the procedure he is agreeing to.[379] To what constitutes the 'nature' of a medical procedure, no general answer can be given other than to say that it is a relatively narrow notion encompassing by description the character of the acts to be done by the doctor and, qualitatively, the intended effect of the procedure and its purpose.[380] Thus, the information needs to state in 'broad terms' what is to be done to the patient and why.[381] This information need not descend into minute, or indeed any, real detail. In practice, judges have given considerable leeway in determining what information is relevant to the nature and purpose of a procedure and what is co-lateral to that and, therefore, immaterial to the reality of the patient's consent.[382] If the patient's consent is not 'real' then a doctor commits battery by touching the patient. However, where the patient does not understand the 'nature' of the procedure, a doctor who mistakenly and reasonably believes that he does, may have a defence in that the patient may be estopped from denying he possessed the information if he has led the doctor 'reasonably to assume the relevant information was known to him'.[383]

The only reported English case in which a health care professional has been held liable for battery is *Appleton* v *Garrett*.[384] The defendant carried out extensive restorative treatment on teeth which were healthy, for financial gain. Dyson J held that the defendant had committed a battery on his patients, and concluded that the patients' consent were not 'real' in respect of those teeth that were healthy. The above judgment affirms that if a patient consented to a different procedure from that which is in fact performed, her consent will not be effective, and the doctor might be found liable for unlawful touching. In *R* v *Tabassum*[385], T who had no medical

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378 Andrew Grubb, *Principles of Medical Law*, 2nd edn, Oxford University Press, 2004,p.171.
379 *Chatterton* v *Gerson* [1981] QB 432,443 per Bristow J.
380 Andrew Grubb, *Principles of Medical Law*, 2nd edn, Oxford University Press, 2004,p.172.
381 *Chatterton* v *Gerson* [1981] QB 432.
382 Andrew Grubb, *Principles of Medical Law*, 2nd edn, Oxford University Press (2004), p.172.
383 *Sidaway* v *Bethlem Royal Hospital Governors* [1985] 1 All ER 643, per Lord Diplock, p.658.
384 [1997] 8 Med LR 75.
385 [2002] 2 Cr App Rep 328 (CA).

qualifications at all was convicted of indecent assault after he persuaded three complainants to consent to him on showing them how to carry out breast self-examination. Each complainant said they had only consented because they thought T had medical qualifications or relevant training. The Court of Appeal upheld his conviction on the ground that 'consent was given because they mistakenly believed that the defendant was medically qualified and that, in consequence, the touching was for a medical purpose. As this was not so, there was no true consent. In contrast, in *R* v *Richardson*[386], a dentist continued to treat her patients after she had been suspended from practicing. Her patients were not mistaken as to her identity, because she had treated them before, but as to her qualifications to practice. The Court of Appeal stated that 'either there is consent to actions on the part of a person in the mistaken belief that he or they are other than they truly are, in which case it is assault or, short of this, there is no assault'.[387] Because the complainants were fully aware of the identity of the appellant', the Court of Appeal overturned her conviction.

The advantage of an action in battery is that it is not necessary to establish that any physical harm has been caused by the inadequate disclosure. The judges have deplored reliance upon battery in medical cases.[388] They have done for a number of reasons. For example, a doctor's decision not to treat a patient could not form the basis of an action in battery, even where there was wholly inadequate disclosure of the risks of not being treated.[389] As Emily Jackson[390] notes:

> Medical treatment can only amount to battery if there has been some sort of physical contact between doctor and patient. Hence, while an action in battery might be relatively straightforward if the treatment in question is surgery, there are many medical decisions which do not involve touching, and which would therefore be unaffected by a more robust application of the tort of battery. The prescription of drugs, for example, does not involve any physical contact, and so a patient who is inadequately informed about a medicine's side-effects could not bring an action in battery.

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386 43 BMLR 21 (CA).

387 Id.

388 *Sidaway* v *Bethlem Royal Hospital Governors* [1985] 1 All ER 643, 650. per Lord Scarman.

389 Marjorie Maguire Shultz, "From Informed Consent to Patient Choice: A New Protected Interest" 95 *Yale Law Journal* 219 (1985).

390 Emily Jackson, *Medical Law, Text, Cases and Materials*, 2nd edn, Oxford University Press (2010), p.177.

5.4.2.2.2. *Negligence*

From the above discussion it is clear that English law is reluctant to invoke law of battery in the context of medical care. Hence, the next option available to patient is to argue that the doctor's failure to disclose information about their treatment amounted to negligence.

5.4.2.2.2.1**.** Duty to Inform

The courts in the United States had categorized the doctor-patient relationship as fiduciary, thus giving rise to a duty to inform.[391] However, common law has never regarded the doctor-patient as falling into the category of special relationship.[392] In *Sidaway* v *Board of Governors of the Bethlem Royal Hospital*[393], when asked to recognize the doctor-patient relationship as fiduciary, the House of Lords expressly refused and stated that its legal origins lay in the law of contract.[394] Accordingly, once a doctor's assistance has been sought and the doctor has undertaken to offer treatment, a doctor-patient relationship comes into existence. This undertaking includes a duty to act affirmatively on the patient's behalf. This, in turn, translates into a duty to inform so as to obtain from a patient a valid consent.[395]

5.4.2.2.2.2. Standard of Disclosure

Once the courts moved from a battery-based approach, in which the patient's lack of consent made out a prima facie case, to negligence, they had to locate a source of a standard of disclosure and a test for measuring its adequacy. Three choices were available. First, the standard for disclosure of material information could be set by professional practice, applying the traditional medical malpractice rule. Second, balancing the patient's autonomy interests against the possibility that some patients might want too much information, the standard could be set by what a reasonable patient would want to know. Third, a pure subjective standard could be chosen, asking what particular patient considered important.

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391 *Canterbury* v *Spence*, 464 F.2d 772 (D.C. Cir. 1972). see also, Cobbs v Grant (1972) 502 P 2d 1.
392 Andrew Grubb, *Principles of Medical Law*, 2nd edn, Oxford University Press, 2004,p.180.
393 *Sidaway* v *Bethlem Royal Hospital Governors* [1985] 1 All ER 643, pp. 650-51.
394 Id.
395 Andrew Grubb, *Principles of Medical Law*, 2nd edn, Oxford University Press (2004), p.180.

5.4.2.2.2.2.1 The Reasonable Physician Test

The professional disclosure standard, measuring the duty to disclose by the standard of the reasonable medical practitioner in similar situation, requires expert medical testimony to establish the content of a reasonable disclosure. This professional standard is justified by three arguments. First, it protects good medical practice.[396] Secondly, a patient-oriented standard, the courts fear, would force doctors to spend unnecessary time discussing every possible risk with their patients, thereby interfering with the flexibility that physicians need to decide on the best form of treatment. Third, only physicians can accurately evaluate the psychological and other impact that risk would have on particular patients.

The starting point for an examination of professional standard of care must be *Bolam* v *Friern Hospital Management Committee*[397]. The case concerned with the doctor's failure to warn the patient about the risks involved in electroconvulsive therapy and to advise him that these could be minimized by the use of restraints or muscle relaxants. It was held that to prove breach of duty a patient would have to show that no responsible doctor would have done what was done in similar situation. Further McNair J suggested that the doctor might act properly in withholding information about a risk which he considered to be 'minimal'. Similarly, Kansas Supreme Court in *Natanson* v *Kline*[398] fixed the required content of a physician's disclosure by reference to that which physicians commonly made when handling a similar case. The first House of Lords case to consider the question of how much information patients should be given before consenting to medical treatment was in *Sidaway* v *Board of Governors of the Bethlem Royal Hospital*[399]. The majority of the House of Lords concluded that the level of disclosure required should be decided on the basis of the *Bolam* test. This test holds that a doctor will not be negligent if he follows a practice accepted as proper by a responsible body of medical opinion. Its application to a risk disclosure case means that a doctor need only disclose those

396 See, *Woolley* v *Henderson*, 418 A.2d 1123 (Me. 1980).

397 [1957] 2 All ER 118.

398 350 P.2d 1093 (Kan.1960). In this case a woman who was suffering from breast cancer was subjected to cobalt therapy after mastectomy in order to prevent it's further spreading to the other parts of the body. She sustained injuries as a result of the therapy. She sued the radiologist for his lapse to warn of the risks inherent in the procedure. The action was allowed and the radiologist was held guilty of negligence and not of trespass.

399 [1985] 1 All ER 643.

risks which other doctors would also disclose. No room is left in this test for consideration of what the patient needs to know in order to make an autonomous choice.[400] It is not, therefore, an approach consistent with patient autonomy or the right to self-determination.[401] Similarly in *Gold* v *Haringey Health Authority*[402] and *Blyth* v *Bloomsbury Health Authority*[403] the court followed the Bolam approach to patient information. However, subsequent to the *Bolitho*[404] case, in which it was held that a responsible medical opinion must rest upon a logical basis in order to be relied upon, the Court of Appeal has rethought the application of *Bolam* to this issue. For example, in *Pearce* v *United Bristol Healthcare NHS Trust*[405], Lord Woolf MR[406], considered the impact of *Bolitho* upon *Sidaway* and concluded that if there is a significant risk which would affect the judgment of a reasonable patient, then in the normal course it is the responsibility of a doctor to inform the patient of that significant risk, if the information is needed so that the patient can determine for him or herself as to what course he or she should adopt. This formulation is reminiscent of Lord Scarman's 'prudent patient' test. This approach has subsequently been approved by the House of Lords in *Chester* v *Afshar*[407] when Lord Steyn[408] stated:

> A surgeon owes a legal duty to a patient to warn him or her in general terms of possible serious risks involved in the procedure… In modern law medical paternalism no longer rules and a patient has a prima facie right to be informed by a surgeon of a small, but well established, risk of serious injury as a result of surgery.

Further, Lord Steyn argues that 'a patient's right to an appropriate warning from a surgeon when faced with surgery ought normatively to be regarded as an important right which must be given effective protection whenever possible'.[409] In *Smith* v

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400 Elizabeth Wicks, *Human Rights and Healthcare*, Hart Publishing, Oregon (2007), p.84.
401 Id.
402 [1987] 2 All ER 888.
403 [1993] 4 Med LR 151. In this case a patient who was a trained nurse took a controversial contraceptive injection. It had a number of side effects. She was told of the risk of menstrual irregularity, but not other side effects inspite of specific questions on her part. She brought an action against the doctor on the ground of non-disclosure of risk. The court held that even if interrogated by a patient, it is not obligatory for a doctor to disclose the risks if a responsible body of medical opinion supports non-disclosure.
404 *Bolitho* v *City & Hackney Health Authority* [1998] AC 232.
405 (1998) 48 BMLR 118.
406 Id.
407 [2004] 4 All ER 587.
408 Id. para 16.
409 Id. para 17.

Tunbridge Wells HA[410] it was held that the doctor's duty is not only to inform the patient but also to take reasonable steps to ensure that the patient understands to what treatment he or she is consenting to.[411] In *Al Hamwi* v *Johnston*[412] it was laid down that only reasonable steps have to be taken. The doctor does not need to be absolutely sure that the information has been understood. In *Birch* v *University College London Hospital*[413] Cranston J held that there will be cases where 'unless the patient is informed of the comparative risks of different procedures she will not be in a position to give her fully informed consent to one procedure rather than another'. Hence, Lord Walker in *Chester* v *Afshar*[414] emphasized that a patient had the right to be told not only about the treatment being offered, but also alternative or variant treatments that could be used. An issue to be considered here is whether the standard of care and level of disclosure by a physician vary depending upon the patient asking specific questions about potential risks? In *Sidaway* Lord Bridge said, obiter, that a doctor's duty when asked a question is 'to answer both truthfully and as fully as the questioner requires'.[415] Subsequently in *Blyth* v *Bloomsbury Health Authority*[416], however, the Court of Appeal applied the *Bolam* test even to the issue of asking questions.[417] But, in *Pearce*, Woolf LJ stated that 'if a patient asks a doctor about the risk, then the doctor is required to give an honest answer'.[418] This seems the correct approach provided that it applies to questions regarding risks which would not objectively be regarded as material. Risks which would be regarded as material by a reasonable patient should be disclosed regardless of whether the patient asks about them.[419] The right to know must be the same for all patients regardless of whether they remember, and are able, to ask the correct questions. If a question is asked, however, a doctor should be honest in his reply. As Elizabeth

410 [1994] 5 Med LR 334
411 Id. p.339.
412 [2005] EWHC 206.
413 [2008] EWHC 2237 (QB), para 74.
414 Id. para 95.
415 *Sidway* v *Bethlem Royal Hospital* [1985] 1 All ER 643, p.661.
416 [1993]4 Med LR 151.
417 Id. p.157.
418 (1998) 48 BMLR 118, p.120.
419 Elizabeth Wicks, *Human Rights and Healthcare*, Hart Publishing, Oregon (2007), p.87.

Wicks argues, such a 'principled approach bodes well for the future protection of patient's rights'.[420]

The professional practice standard is determined by the medical community and it emphasizes the patient's best medical interest. Expert witnesses are in best position to determine whether this standard has been upheld or violated. This standard is frequently criticized because it assumes that the physician is capable of determining what is in the patient's best interest. A key consequence of using this approach is that a patient could not make out an informed consent claim without introducing expert testimony as to what other physicians normally tell their patients in similar cases. This posed two obvious problems for prospective plaintiffs. The first was the difficulty of finding physicians, willing to testify as expert witnesses against their colleagues on a matter of questionable substance. Second, the approach left the entire question of what should be disclosed up to the discretion of the physician community, which might exercise that discretion with little regard for what patients want to know.

5.4.2.2.2.2.2. The Reasonable Patient Test

According to this test, law requires disclosure of all information relating to medical treatment which a reasonable patient would consider relevant. In *Canterbury* v *Spence*[421], the court for the first time held that 'a risk is material when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy'. The decision for the first time changed the perception that the disclosure of information was a part of professional knowledge and skill and, as such, subject to a standard imposed by professional body. *Canterbury* v *Spence*[422] marked a departure from the *Bolam* standard towards one in which the patient's right to be informed about treatment was to be the starting point for a consideration of the physician's duty to warn. For

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420 Id. p.86.

421 464 F 2d 772 (DC, 1972). Mr. Canterbury developed paralysis after he fell off his hospital bed while urinating, subsequent to having surgery on his back. The court held that Mr. Canterbury should have been told of the risk of paralysis even though it was not clear whether the paralysis was caused by the surgery or as a result of the fall. According to the court, true informed consent only exists when patients have an opportunity to evaluate the risks and benefits of all reasonable treatment options.

422 Id.

practical reasons, however, the rights of any individual patient to be informed were to be constrained by what a reasonable person in the position of the patient would require. The physician had to work this out, not by reference to his colleagues, but by abiding to a rule of reason and via conduct 'prudent under the circumstances'.[423] This approach was soon followed in a Californian case, *Cobbs* v *Grant*.[424]

The Canadian Supreme Court agreed with the reasoning of *Canterbury* v *Spence*[425] in *Reibl* v *Hughes*[426] when Laskin CJC[427] held:

> To allow expert medical evidence to determine what risks are material and, hence, should be disclosed and, correlatively, what risks are not material is to hand over to the medical profession the entire question of the scope of the duty of disclosure, including the question whether there has been a breach of that duty. Expert medical evidence is, of course, relevant to findings as to the risks that reside in or are a result of recommended surgery or other treatment. It will also have a bearing on their materiality but this is not a question to be concluded on the basis of the expert medical evidence alone. The issue under consideration is a different issue from that involved where the question is whether the doctor carried out his professional activities by applicable professional standards. What is under consideration here is the patient's right to know what risks is involved in undergoing or forgoing certain surgery or other treatment.

The prudent patient test was favoured in common law by Lord Scarman in his powerful dissent in the landmark English case of *Sidway*. He recognized that in cases concerning a failure to disclose risks, 'the court is concerned primarily with a patient's right'.[428] Lord Scarman[429] stated that:

> The doctor's duty arises from the patient's rights. If one considers the scope of the doctor's duty by beginning with the right of the patient to make his own decision whether he will or will not undergo the treatment proposed, the right to be informed of significant risk and the doctor's corresponding duty are easy to understand, for the proper

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423 Id. p.788.
424 *Cobbs* v *Grant* 502 P.2d 1(Cal. 1972).
425 464 F 2d 772 (DC, 1972).
426 (1980) 114 DLR (3d). Reibl underwent surgery for removal of an occlusion in the left internal carotid artery. Prior to the surgery the respondent did not inform the appellant specifically about the risk of stroke. The court allowed the appeal and granted damages.
427 Id. p.13.
428 *Sidaway* v *Board of Governors of the Bethlem Royal Hospital* , [1985] 1 All ER 643, 654.
429 Id.

> implementation of the right requires that the doctor be under a duty to inform his patient of the material risks inherent in the treatment.

This is clearly a rights-based approach to the issue of informed consent and unfortunately the other Law Lords in *Sidaway* did not share Lord Scarman's view. For example, though, Lord Bridge was impressed by the line of reasoning in *Canterbury* v *Spence* [430], he rejected the reasonable patient standard as the benchmark for determining the contents of the duty to warn. He gave three reasons. Firstly, he held that it gave 'insufficient weight to the realities of the doctor-patient relationship'.[431] He held that a doctor could not be expected to educate the patient to his own standard, or to explain remote risk which would be disproportionately interpreted by the patient.[432] Secondly, he felt that it was unrealistic to deprive the court of medical opinion in relation to risk disclosure. Finally, he rejected the objective standard because it is so imprecise as to be meaningless. If it is to be left to individual judges to decide for themselves what a 'reasonable person in the patient's position would consider a risk of sufficient significance that he should be told about it, the outcome of litigation in this field is likely to be quiet unpredictable'.[433]

A difficulty with the prudent patient test is in deciding whether it is objective or subjective. From a reasonable patient's perspective, the scope of disclosure includes any information, including benefits and risks of the proposed treatment and reasonable treatment alternatives, that a patient would consider material to a treatment decision.[434] Rather, the physician is expected to employ medical judgment in recommending a course of treatment and identifying risks and alternatives[435], while remaining mindful of the patient's informational needs.[436] Thus, the content of the disclosure rests in the first instance with the physician. It is only he who is in a position to identify particular dangers; at all times he must make a judgment, in terms of materiality, as to whether and to what extent revelation to the patient is called for. He cannot know with complete exactitude as to what the patient would

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430 464 F 2d 772 (DC, 1972).
431 Id. p.662.
432 Id.
433 Id. p.662.
434 *Canterbury* v *Spence*, 464 F.2d 772 (D.C. Cir. 1972).
435 Id. p.787.
436 Id.

consider important to his decision. The case of *Flanagan* v *Wesselhoeft* [437] illustrates an instance in which materiality from the patient's perspective departed from medical judgment. In *Flanagan*, the plaintiffs discovered a small node that had developed below their daughter's ear and sought the defendant physician's medical advice. The physician examined the node and stated that it would have to be removed through surgical excision. Before removing the node, the physician did not discuss any options other than surgery and mentioned no risks other than minor bleeding and infection. Following excision and analysis, the node proved to be benign and the patient's wound healed successfully.[438] However, several weeks after the procedure, the patient's right shoulder dropped, resulting in significant distress. A pediatric surgeon discovered that the patient's spinal nerve had been damaged during the node excision procedure. The surgeon reconnected the severed nerve and the patient fully recovered.[439] The patient's parents filed suit, claiming, in part, that Dr. Wesselhoeft failed to disclose fully the risks and alternatives to excision and that he committed medical negligence when he severed the patient's nerve. At trial, Dr. Wesselhoeft received judgment as a matter of law on both claims, largely because the plaintiff's expert, an out-of-state pediatric surgeon, was not permitted to testify. The Rhode Island Supreme Court overturned the trial judgment and granted a new trial in which the expert was permitted to testify. Applying Rhode Island's patient-oriented disclosure standard, the jury in the second trial concluded that Dr. Wesselhoeft failed to obtain informed consent because he neither discussed the likelihood that the node was malignant nor disclosed alternatives to surgical excision, such as needle biopsy. Moreover, he failed to disclose the possibility that surgery could result in nerve damage, a serious and potentially life-threatening complication.[440] *Flanagan* illustrates the substantial divergence of opinion regarding the adequacy of informed consent in the minds of a layperson and that of a physician. In *Flanagan*, the physician exercised his best medical judgment in recommending excision and disclosed the most common risks, which means bleeding and infection. In disclosing these risks, however, he failed to consider the

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437 712 A.2d 365 (R.I. 1998).
438 Id. p.366.
439 Id. p. 367.
440 765 A.2d 1203 (R.I. 2001) (*Flanagan II*). pp.1207-08.

more remote,[441] but very serious risk that might cause the reasonable patient or a surrogate to forgo the recommended treatment. Additionally, he failed to disclose alternatives, such as a less-invasive needle biopsy, which might also reveal whether the node was malignant and which would minimize serious risks. The lesson to be learned from *Flanagan* is readily apparent i.e., under the patient-oriented standard, physicians must subordinate medical judgment to patients' informational needs, realizing that patients may attach significance to risks that physicians deem remote and prefer alternatives that physicians do not recommend. Informed consent under this standard is not a question of medical judgment but rather one of individual autonomy and the patient is permitted, at the patient's peril, to elect an alternative that deviates from the recommended treatment.

Hence, the patient-oriented standard presents a potentially significant conflict between treatments that a reasonable patient may wish to consider and treatments a conventionally trained physician has been taught as being the requisite standard of care. If reasonable treatments are coterminous with the standard of care, then the physician's, rather than the patient's, mind should be the object of the reasonableness inquiry.[442] Indeed, if this were the case, then the patient-oriented standard would collapse into the physician-oriented standard. The distinction between the two standards would become one of form, rather than of substance.[443] Thus, if the patient-oriented standard is to have any meaning, then reason, from a patient's perspective, must be understood as broader than the standard of care. In some instances, the patient-oriented standard may require disclosure of treatment alternatives that the physician does not recommend but are nevertheless reasonable from the patient's perspective.

However, the patient-based approach to informed consent tackled the two problems inherent in the professional disclosure standard. First, the required content of the physician's disclosure was measured by the patient's informational needs rather than by what physicians might, or might not, choose to tell their patients. Second, using a patient-based standard meant that patient-plaintiff's no longer had to

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441 Id. Expert testimony established that the risk of a severed nerve was approximately one percent.

442 James A. Bulen, "Ethical And Legal Aspects Of Informed Consent To Treatment", 24 *J. Legal Med.* 331(2003), p.335.

443 Id.

establish by expert testimony what the 'standard disclosure' was for a particular condition or treatment. They could simply assert that the undisclosed information was something that an 'average, reasonable patient' would want to know.[444]

5.4.2.2.2.2.3. The Subjective Standard

Under this standard, a physician is obligated to disclose information that a particular patient would find material in making a decision.[445] The subjective standard of disclosure acknowledges that people have highly variable informational needs, and imposes a duty upon doctors to tailor their disclosures according to the individual patient's own priorities and concerns.[446] For example in *F* v *R*[447] Justice King while refusing to apply the *Bolam* principle held that the ultimate question, however, is not whether the defendant's conduct accords with the practices of his profession or some part of it, but whether it conforms to the standard of reasonable care demanded by the law.[448] Also, the amount of information or advice which a careful and reasonable doctor would disclose depended upon the nature of treatment; the desire of the patient for information; the temperament and health of the patient; and the general surrounding circumstances.[449] Hence, it is the courts and not the medical profession which will determine the standard of care. Similarly, in *Rogers* v *Whitaker*[450] the High Court agreed with the judgement in *F* v *R* in allowing that 'a doctor has a duty to warn a patient of a material risk inherent in the proposed

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444 Theodore R, Arnold J Rosoff, Christopher White, "Informed Consent to Medical and Surgical Treatment" in Sandy Sanbar S, et al., *Legal Medicine*, 6th edn., Mosby Inc., Pennsylvania (2004),p.345.

445 Berg, Jessica W.,*et. al*, *Informed Consent: Legal Theory and Clinical Practice*, Oxford University Press, Oxford (2001), p.51.

446 Emily Jackson, *Medical Law, Text, Cases and Materials*, 2nd edn, Oxford University Press (2010), p.190.

447 (1983) 33 SASR. A woman went to her gynaecologist and asked to be sterilised by Tubal ligation. The doctor did not warn her that there was a less than 1% chance that she would fall pregnant after the operation. The woman had the procedure, became pregnant again. She sued her gynaecologist for negligence.

448 Id. p.194.

449 Id.

450 (1992) 175 CLR 479. A patient had a scar tissue in her right eye causing damage to the vision. She was almost totally blind in that eye. Her left eye was normal. The doctor performed an operation to remove the scar tissue in order to improve the vision. The patient questioned about the possible complications of the operation. But she failed to question whether the operation would cause damage to the left eye. There was a chance of sympathetic ophthalmia developing. The doctor failed to disclose it. As a result of the operation the risk of ophthalmia materialized. The patient lost vision in her left eye. There was evidence to the effect that the professional practice was against the disclosure unless specifically asked. Inspite of the absence of specific question and remote possibility of risk, the court held that the failure to warn was a breach of doctor's duty to take care.

treatment'. In a combined judgement Mason, Brennan, Dawson, Toohey and McHugh JJ[451] defined a 'material risk' as:

> In the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it'.

This was a departure from the prudent patient standard adopted by *Canterbury* v *Spence* in the United States. The High Court in Australia[452] held that 'even if a court were satisfied that a reasonable person in the patient's position would be unlikely to attach significance to a particular risk, the fact that the patient asked questions, revealing concern about the risk, would make the doctor aware that this patient did in fact attach significance to the risk'. Though, acknowledging that the duty a doctor owes towards a patient is a 'single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgment', the majority held that 'the factors according to which a court determines whether a medical practitioner is in breach of the requisite standard of care will vary according to whether it is a case involving diagnosis, treatment or the provision of information or advice; the different cases raise varying difficulties which require consideration of different factors.[453] The standard of care required of a practitioner in relation to diagnosis and treatment would involve a decision in which 'responsible professional opinion will have an influential, often a decisive role to play'.[454] In relation, however, as to whether a patient has sufficient information to make informed decisions about healthcare, the majority held: 'generally speaking, it is not a question, the answer to which depends upon medical standards and practice'.[455] Hence, Bolam standard is abandoned and is now to be determined by what the patients want to know.

Presumably the standard to which a doctor was to be held responsible in relation to diagnosis and treatment was to be a standard imposed by the court, not standards recognized by the medical profession. This would leave the clinician in an

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451 Id. p.490.
452 Id. p.487.
453 Id. p. 489.
454 Id.
455 Id. p.489-90.

untenable position of not being able to practice with any degree of certainty given that, even if one were to treat a patient in such a way that it aligned with current professional standards and practice, the court could determine that this represented an inadequate standard of care is not to be determined solely by the medical profession, it is easy to see that in the resulting confusion a rights' claim by a consumer might trump both views.

5.4.2.2.3. *Causation*

Even if a patient is able to prove that the information given was inadequate, the patient still faces an uphill task in claiming damages. This is because the patient must show that as a result of negligent non-disclosure the patient suffered injury or loss. In other words, it requires that a patient prove that he would not have undergone the treatment if he had known of the risks. Causation will therefore be established if the claimant can prove that proper disclosure would have caused them to refuse the treatment which has resulted in their injury.[456] In *Smith* v *Barking, Havering and Brentwood Health Authority*[457], Hutchison J suggested that an objective test should be used to test the truth of the patient's assertion from the witness box that she would not have consented if she had been told about a particular risk. In the case of *Chester* v *Afshar*[458]the House of Lords adopted an innovative approach to causation when Justice Bristow[459] held:

> In my judgement what the court has to do in each case is look at all the circumstances and say 'Was there a real consent?' I think that justice requires that in order to vitiate the reality of consent there must be a greater failure of communication between doctor and patient than that involved in a breach of duty if the claim is based on negligence. When the claim is based on negligence, the plaintiff must prove not only the breach of duty to inform, but that had the duty not been broken she would not have chosen to have the operation. In my judgement, once the patient is informed in broad terms of the nature of the procedure which is intended, and gives her consent, that consent is real and the cause of the action on which to base a claim for failure to go into risks and implications is negligence, not trespass.

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456 Emily Jackson, *Medical Law, Text, Cases and Materials*, 2nd edn, Oxford University Press (2010), p.197.
457 [1994] 5 Med LR 285.
458 [2004] 4 All ER 587.
459 Id. p.265.

The view of Justice Bristow was later adopted in *Sidaway* v *Bethlem Royal Hospital Goverors*[460]. Although bringing her action in negligence, the Court of Appeal stated its view on the scope and application of the tort of battery. Lord Scarman in the House of Lords commented that 'it would be deplorable to base the law in medical cases of this kind on the torts of assault and battery'.[461]

To conclude, if the doctor is guilty of not obtaining some form of consent from the patient, provided he was not fraudulent or deliberately misleading, he is negligent, rather than guilty of battery. For the doctor to be negligent three basic elements needs to be present. Firstly, the doctor has to owe the patient a duty of care. This may seem obvious but given advancing technologies the duty of care may be extended in ways of which the non-legal mind of the clinician is simply unaware. Second, there has to have been a breach of this standard of care. The standard is determined by reference to medical opinion and the courts decide if this standard has been met or not. Finally the patient has to demonstrate that it was the breach in the duty that caused the damage and the damage was not 'too remote'.[462] Although the onus of proof is on the patient and the requirements for determining the negligence of the clinician are quite a burden, it is also worth noting that for the clinician maintaining a standard where the borders between acceptable and non-acceptable care may be quite fuzzy, is no less burdensome.[463]

The system which exists in New Zealand can be considered as an alternative to both battery and negligence. The Code of Patients' Rights offers protection to patients' interests in information disclosure. The breach of the Code does not depend upon proof of injury, nor of a causal link between any injury suffered. It is not necessary to show that the patient suffered harm as a result of a failure to be sufficiently informed. Thereby, the Code recognizes that a patient is likely to want a wider range of information than about risks in making decisions about treatment. This reflects the paramount interest that the duty of disclosure and the concept of

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[460] [1985] 1 All ER 643 (HL).
[461] Id. p. 650.
[462] Kerridge, Ian, Michael Lowe, and John McPhee, *Ethics and Law for Health Professions*, The Federation Press, Leichhardt (2005), p.140.
[463] Id.

informed consent is designed to secure the individual's autonomy and right to decide in an informed manner, not just the interest in bodily safety.[464]

5.4.2.2 *Indian Position*

Although in India we do not have much litigation, unlike in the West, it may be concluded that the courts have assigned immense significance to the requirement of informed consent. For example, in *Samira Kohli* v *Dr. Prabha Manchanda*[465] the apex court held that failure to obtain consent for removal of reproductive organs without taking consent amounts to an unauthorized invasion and interference with the patient's body. A medical practitioner in India has a duty to provide all the necessary information to the patient in a language that is understandable to him. Regarding the quantum of information, there are no clear parameters laid down by the courts. Therefore, it is reasonable information which a doctor deems fit considering best practices. Considering the knowledge gap in this regard, the professional regulatory body for medicine can play an important role in establishing standards. Indian Medical Council[466] noted:

> The physician should neither exaggerate nor minimize the gravity of the patient condition.
>
> He must ensure himself that the patient, his relatives or his responsible friends have such knowledge of patient's condition as well serve the best interest of the patient and the family.

Doctors in India do not follow the practice of informing individuals of various dimensions of their illness, available alternatives, side-effects and related matters. For example, in the late-90's, joint research by the Indian Council for Medical Research and All-India Institute of Medical Sciences revealed that 1,100 women patients were not informed about the existence of pre-cancerous lesions.[467] In India, *Bolam* remains the standard of risk disclosure. For majority of patients' doctor's experience or intuition is acceptable and welcome so long as healthcare is free or cheap; and whatever the doctor decides as being in their interest, is usually

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[464] Joanna Manning, "Informed Consent to Medical Treatment: The Common Law and New Zealand's Code of Patients' Rights", 12 *Medical Law Review* 181 (2004).

[465] (2008) CPJ 56 (SC).

[466] See, Indian Medical Council (Professional conduct, Etiquette and Ethics) Regulations, 2002.

[467] Rakesh Shukla, "SC upholds the importance of informed consent", viewed 21st Sep 2013, http://infochangeindia.org/women/judicial-interventions-and-women/sc-upholds-the-importance-of-informed-consent.html

unquestioningly accepted.[468]Also, there have been no authoritative pronouncements by the Indian courts on the issue of the nature of consent required for medical procedures and operations. Rare exceptions apart, the courts have acquiesced in the 'benevolent paternalism' of the profession.

5.4.3. Voluntariness

Once it has been determined that a person has the capacity to make a particular decision at a particular time, a further requirement for consent to be valid is that it must be given voluntarily and freely, without pressure or undue influence being exerted.[469] In the context of medical care, it will be rare for patients to be coerced by direct threats into consenting to medical treatment, but more subtle forms of pressure are possible. For example, in *Re T*[470] the court recognized that pressure to consent to, or to refuse medical treatment is unlikely to consist in physical force or duress, and much more likely to take the form of persuasion. The closer the relationship with the persuader, the harder it may be for the patient to resist complying with their views.[471] Discussing undue influence Lord Donaldson MR[472] stated that:

> A special problem arises if at the time the decision is made the patient has been subjected to the influence of some third party. This is by no means to say that the patient is not entitled to receive and indeed invite advice

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468 *Samira Kohli* v *Dr. Prabha Manchanda & Anr.* 2008 (2) SCC 1, para 26.

469 Meisel A, Roth LH, Lidz CW, "Toward a model of the legal doctrine of informed consent", 134 *Am J Psychiatry* 285 (1997), p.287. see, s.90 of IPC. **Consent known to be given under fear or misconception.** A consent is not such a consent as is intended by any section of this Code, if the consent is given by a person under fear of injury, or under a misconception of fact, and if the person doing the act knows, or has reason to believe, that the consent was given in consequence of such fear or misconception;
Consent of insane person- if the consent is given by a person who, from unsoundness of mind, or intoxication, is unable to understand the nature and consequence of that to which he gives his consent;
Consent of child- unless the contrary appears from the context, if the consent is given by a person who is under twelve years of age.

470 *Re T (adult: refusal of treatment)* [1992] 4 All ER 649. T was injured in a road traffic accident when pregnant. She had been brought up by her mother who was a Jehovah's Witness but T herself was not a follower. When alone with her mother T told the medical staff that she did not want a blood transfusion and she signed a form to that effect. At that time the hospital authorities did not tell her that a blood transfusion might be necessary in order to save her life and was reassured by medical staff that other solutions could be used. Caesarean was performed but it resulted in stillbirth. T's condition deteriorated and a blood transfusion became necessary. But doctors were restrained by her refusal of consent. T's father and boyfriend applied to the court for assistance. The court found T to be mentally incompetent and thus authorised treatment in her best interests.

471 Id.

472 [1992] 4 All ER649, 662.

> and assistance from others in reaching a decision, particularly from members of the family. But the doctors have to consider whether the decision is really that of the patient...The real question in each such case is, does the patient really mean what he says or is he merely saying it for a quiet life, to satisfy someone else or because the advice and persuasion to which he has been subjected is such that he can no longer think and decide for himself? In other words, is it a decision expressed in form only, not in reality?

Therefore, Lord Donaldson pointed to two main considerations when examining influences. The first is the strength of will of the patient. If the patient is in pain, depressed or tired or being treated with drugs, he or she is less likely to resist the influence of others. The second is the patient's relationship with the persuading party. In *Mrs U* v *Centre for Reproductive Medicine*[473] the patient was influenced by the clinician. The facts of Mrs. U present us with a novel context for the operation of broad notions of undue influence. In this case Mrs. U and Mr. U were attempting to overcome the effects of Mr. U's earlier vasectomy so as to enable them to produce a child. The means adopted was surgical retrieval of his sperm which was then to be used in an IVF procedure involving Mrs. U. Before the process was started, Mr. U completed two consent forms. The first consent form was the form of the centre itself and related to the storage and disposal of sperm. It noted that 'the ethical policy of this unit is not to perform posthumous insemination'. In signing the second form, required by the Human Fertilization and Embryology Act 1990, Mr. U consented, in the event of his death, for the continued storage of his sperm for use in IVF. In a preparation meeting after the extraction of the sperm and prior to IVF, various discussions took place with a nursing specialist. As a result of these discussions, the consent form was altered by Mr. U, such that, in the event of his death, the sperm would be allowed to perish rather than it being stored for use in IVF. In the meantime, Mr. U died before any successful IVF could take place. Given the amended consent form, the centre was under an obligation to dispose of the sperm. Mrs. U argued, however, that the amended consent form was tainted by the nursing specialist having exerted undue influence and so the amended consent was invalid. Mrs. U argued that her husband amended the form, because he formed the impression that treatment would discontinue if the form was not signed. This argument of Mrs. U was largely favoured by the President of the Family Division of the High Court of Justice. But the issue before the court was whether undue influence was present

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[473] *Mrs U* v *Centre for Reproductive Medicine* (unreported, High Court of Justice, Family Division, The President, 25 January 2002)

so as to vitiate Mr U's amendments made on 25th October? The President while reflecting on opinions delivered in *Re T* concluded that[474]:

> . . . it is difficult to say that an able, intelligent, educated man of 47, with a responsible job and in good health, could have his will overborne so that the act of altering the form and initialing the alterations was done in circumstances in which Mr. U no longer thought and decided for himself . . . He succumbed to the firmly expressed request of Ms. Hinks and under some pressure. But to prove undue influence, Mr. U has to show something more than pressure.

The Court of Appeal makes it clear that the test for undue influence is essentially the same across the board, property or otherwise, the weaker party's will must have been so overborne as to prevent its independent exercise. Although Mrs. U maintains the strict test as to what that influence must amount to, it is not difficult to imagine that in many medical cases a weak patient simply trusts the doctor's opinion and accedes to what is recommended. In doing so, it purported to distinguish the situation from all other incidents of undue influence recognized at law as this was not like deciding upon the validity or enforcement of a will, gift or other transaction, which may have been procured by the undue influence of the person who will benefit from it. The Centre did not stand to benefit from the withdrawal of consent. Nor is it like deciding upon the lawfulness of medical treatment. There are other justifications for performing life-saving medical treatment apart from the possession of an effective consent. There is no justification for continuing to store human sperm. Hence, the opinion of court was that a Centre having in their possession a form of consent should be both entitled and expected to rely upon that form according to its letter, unless and until it can clearly be established that the form does not represent a valid decision by the person apparently signing it. The most obvious examples are forgery, duress, or mistake as to the nature of the form being signed. The equitable concepts of misrepresentation and undue influence may have a part to play but the courts should be slow to find them established in such a way as to supply a centre with a consent which they would not otherwise have. However, the absence of a 'benefit' requirement in respect of medical service cases,

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[474] *Centre for Reproductive Medicine* v *Mrs U* (unreported, High Court of Justice, Family Division, The President, 25 January 2002) at para 28

while only sensible, does logically mean that there are actually fewer obstacles for the applicant seeking to make out undue influence in those cases.[475]

When medical treatment is given in prisons or a mental hospital there is a potential for treatment offers to be perceived coercively.[476] Prisoners and persons released on bail can be treated without their consent in the interest of justice for society. According to s. 53 of Criminal Procedure Code, a registered medical practitioner can examine an accused by using reasonable force if the examination is requested by the investigating police officer not below the rank of police sub inspector[477]. In *Freeman* v *Home Office (No 2)*[478], the Court of Appeal while rejecting an argument that a prisoner cannot make a free choice and thus give a valid consent recognized that an institutional setting may raise some doubts about the issue. Similarly, in *Kaimowitz* v *Michigan Department of Mental Health*[479] it was held that it 'is impossible for an involuntarily detained mental patient to be free of ulterior forms of restraint or coercion when his very release from the institution may depend upon his co-operating with the institutional authorities and giving consent to experimental surgery'. Therefore, it would be wise to apply particularly stringent requirements of voluntariness within a prison or mental hospital in order to ensure that a purported choice is freely arrived at.

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475 Cameron Stewart, "Undue influence, consent and medical treatment", 96 *Journal of the Royal Society of Medicine* 598 (2003), p.600.

476 Department of Health , Reference guide to consent for examination or treatment, second edition 2009 , https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/138296/dh_103653__1_.pdf.

477 s.53 of CrPc. **Examination of accused by medical practitioner at the request of police officer**.

(1) When a person is arrested on a charge of committing an offence of such a nature and alleged to have been committed under such circumstances that there are reasonable grounds for believing that an examination of his person will afford evidence as to the commission of an offence, it shall be lawful for a registered medical practitioner, acting at the request of a police officer not below the rank of sub- inspector, and for any person acting in good faith in his aid and under his direction, to make such an examination of the person arrested as is reasonably necessary in order to ascertain the facts which may afford such evidence, and to use such force as is reasonably for that purpose.

478 [1984] 1 All ER 1036. This case concerned with a prisoner who was serving a life sentence. He received medical treatment against his will. He argued that where a doctor was also a prison officer, consent could never be voluntary. The Court of Appeal rejected his argument.

479 42 USLW 2063 (1973).

According to Stewart and Lynch, the primary philosophical basis for the doctrine of undue influence is respect for individual autonomy.[480] Doctors and relatives will often try to persuade patients of the merits of undergoing a procedure which they believe will benefit the patient. As Staughton in *Re T*[481] notes that 'every decision is made as a result of some influence: a patient's decision to consent to an operation will normally be influenced by the surgeon's advice as to what will happen if the operation does not take place'. All forms of persuasion are wholly legitimate, but when consent is extracted with threats of punishment, loss of privileges and threats of further detention, it is coercion, for it takes unfair advantage of the patient's vulnerability.[482] Whatever the circumstances, the issue of voluntariness is an issue of fact.[483] If the patient were confined, or if his liberty were otherwise limited, this should merely put the court on notice to be vigilant in examining the facts.[484]

5.5. LIMITS TO CONSENT

The presence of a patient's consent or that of a proxy determines the legality of a medical treatment or intervention. However, consent from the patient is not always feasible to obtain and is not always required. One of the most broad and generally accepted exception to informed consent is that a physician is not under a duty of disclosure in cases in which it is reasonably believed that disclosure to the patient would pose a serious threat to the patient's well being.[485] For example, in the seminal case of *Canterbury* v *Spence*[486], the court articulated this exception by stating:

> It is recognized that patients occasionally become so ill or emotionally distraught on disclosure as to foreclose a rational decision, or complicate or hinder the treatment, or perhaps even pose psychological damage to the patient. Where that is so, the cases have generally held that the physician is armed with the privilege to keep the information from the patient, and we think it clear that portents of that type may

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480 Stewart, Cameron and Andrew Lynch, "Undue Influence, Consent and Medical Treatment", 96 *Journal of the Royal Society of Medicine* 596 (2003).
481 *Re T (Adult: refusal of treatment)* [1992] 4 All ER 649.
482 Philip Bean, *Mental Disorder and Legal Control*, Cambridge, CUP (1986), p.139.
483 *Freeman* v *Home Office (No 2)*, [1984] 1 All ER 1036.
484 Andrew Grubb, *Principles of Medical Law*, 2nd edition, Oxford University Press, p.203.
485 *Percle* v *St. Paul Fire and Marine Insurance Co.*, 349 So. 2d 1289 (1977).
486 *Canterbury* v *Spence*, 464 F.2d 772.

> justify the physician in action he deems medically warranted. The critical inquiry is whether the physician responded to a sound medical judgement that communication of the risk information would present a threat to the patient's wellbeing.

Apart from the patient's wellbeing the law recognizes situations in which treatment without obtaining consent is accepted. These instances are discussed below:

5.5.1. Procedure must be Legal

One of the requirements for a valid consent is that the consent must comply with the legal procedure to be performed. There are statutory provisions limiting the extent of autonomy, and hence setting limits to what can be consented to. For example, a patient cannot consent to active euthanasia or to be maimed. Those supporting active euthanasia make their claim of a right to die as part of exercising pure liberty rights. The claim, however, is for a third party to assist in the exercise of right, and so is properly regarded not as a pure liberty right but as a claim that obligates others. The problem with maiming is that there is lack of agreement as to what maiming includes. What is one person's maiming is another's sexual gratification or religious observance or beauty enhancement. In *R* v *Brown*[487], the House of Lords posed a question while required to pass judgement on a case involving maiming:

> Where A wounds or assaults B occasioning him actual bodily harm in the course of sadomasochistic encounter, does the prosecution have to prove lack of consent on the part of B before they can establish A's guilt under section 20 or 47 of the Offences Against the Persons Act 1861?

The House of Lords maintained that consent is immaterial when the unlawful act involves a degree of violence such that the infliction of bodily harm is a probable consequence. Similarly, in the absence of a medical direction, genital mutilation of both male and female are considered as maiming. There are statutes limiting the performance of female genital circumcision in many parts of the world though this is

[487] (1994) 1 AC 212, 213. In this case the defendants participated in sadomasochistic homosexual activity in which the victims in each case consented to the activity and did not suffer permanent injury. The defendants faced charges of assault occasioning actual bodily harm and unlawful wounding. The issue before the court was whether consent can be a defense to an assault causing grievous bodily harm? It was held that consent is immaterial when the unlawful act involves a degree of violence such that the infliction of bodily harm is a probable consequence.

performed as part of religious observance in some communities.[488] The same prohibition as in *R* v *Brown*[489] does not extend to cosmetic procedures where the margins between therapeutic benefit, beauty enhancing, and disfigurement can be blurred.

5.5.2. Professional Conduct

The boundaries of the clinical relationship draw attention to another potential limit to consent, for example, when the relationship between clinician and patient becomes sexual. Since Hippocratic times, there has been a widely accepted belief that there is a special trust that is part of the physician-patient relationship and that this trust should not be compromised by the physician entering into any type of improper or sexual relationship with the patient. The Hippocratic Oath[490] states:

> Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustices, of all mischief and in particular of sexual relations, with both female and male persons, be they free or slaves.

The protective role of the state is administered through various statutory bodies such as the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002**.** It provides a mechanism for dealing with matters associated with professional misconduct and upholds breach of trust as a matter of serious professional misconduct.[491] There are a number of arguments for prohibiting sexual relationships with patients as unethical professional conduct. On one account, such consent would be compromised because of the privileged position that the society has granted doctors who have access to the most private and confidential thoughts and feelings of the patient. Entering into a relationship under these circumstances would amount to an abuse of trust, even if the relationship was instigated by the patient or consented to by the patient. Another argument looks to the consequences

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488 See for e.g, The Prohibition of Female Genital Mutilation Act, 2010, Uganda; Crimes Act 1900(NSW), s.45; Law on the Criminal Protection of Minors, 2000, Belgium, Art.29 etc.

489 (1994) 1 AC 212.

490 Breen,Kerry, Vernon Plueckhahn, Stephen Cordner, *Ethics Law and Medical Practice*, Allen & Unwin, Sydney (1997), p.108.

491 See, Regulation **7.**4 of Indian Medical Council. (Professional Conduct, Etiquette and Ethics) Regulations, 2002**, Adultery or Improper Conduct**: Abuse of professional position by committing adultery or improper conduct with a patient or by maintaining an improper association with a patient will render a Physician liable for disciplinary action as provided under the Indian Medical Council Act, 1956 or the concerned State Medical Council Act.

of such relationships, particularly on those patients with psychological problems, whose condition is then exacerbated or left untreated.

5.5.3. Emergency

The general rule is that physician should not extend the treatment beyond what was consented to, except in the context of an emergency.[492] When a patient cannot give consent and care is urgently needed, the physician should presume that the patient would want to be treated as necessary to preserve his or her life. An emergency does not give the physician license to do whatever he or she deems advisable for the patient; it supports only limited measures to preserve the status quo.[493]

5.5.4. The 'Extension Doctrine'

The 'extension doctrine' allows the physician to go beyond the care the patient authorized if an unexpected complication arises that makes it medically advisable to do so.[494] The extension doctrine does not apply to elective or nonessential procedures[495], nor does it apply when the possible need for extension of the authorized procedure should have been anticipated by the physician prior to beginning it. In such a case, the physician must inform the patient before the fact of the possible need for extension and obtain the patient's express consent.[496]

5.5.5. Legislative Exceptions

Consent is not required in instances where overriding the individual's interest may be warranted for the protection of society. Under the Public Health (Control of Diseases) Act 1984 in UK, it is possible to order a person who is

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492 See, *Murray* v *McMurchy* (1949) 2 DLR 442.

493 Sandy Sanbar S *et.al.*, *Legal Medicine*, 6th edn., Mosby, Inc., USA (2004), p. 345.

494 *Kennedy* v *Parrott* 90 S.E.2d 754 (N.C.1956). A physician performing an appendectomy on a patient determined that she had an ovarian cyst that should be excised. Because the patient was under general anesthetic and no person authorized to speak on her behalf was available, the physician decided it was medically appropriate to treat the cyst as part of the same operation. Had he not done so, a second surgery would have been necessary which could prove risky for the patient. The North Carolina Supreme Court upheld the physician's decision to proceed, reasoning that he had not only the right to do so but also the duty to do what sound medicine dictated.

495 *Lloyd* v *Kull*, 329 F. 2d 168 (7th Cir.1964). In this case during an authorized oophorectomy, a surgeon removed a suspicious mole from a patient's thigh without consent. The court held against the surgeon, because there was no necessity to proceed without first getting the patient's consent.

496 Sandy Sanbar S *et.al.*, *Legal Medicine*, 6th edn., Mosby, Inc., USA (2004), p. 345.

suffering from one of a number of 'notifiable' diseases, including cholera, typhus and smallpox,[497] to receive a medical examination if it is in the interests of the patient, the patient's family or the general public.[498] It is also possible to force the patient to enter hospital if the existing circumstances prevent proper care from being taken and there is a serious risk of others becoming infected.[499] Brazier and Harris point out that the result of this is that the patient loses any effective choice in relation to treatment, liberty and privacy due to the fact that the legislation overrides practically all individual liberties.[500] Under the Act it also becomes an offence to knowingly expose others to the possibility of infection with a 'notifiable' disease.[501] Brazier and Harris argue that this is justified as there is no real reason to treat the deliberate or reckless infection of others with such diseases differently to the deliberate infliction of violence upon others when the consequences can be just as harmful, if not more so.[502]

Similarly, Australian jurisdictions authorize medical examinations and treatment of people with sexually transmitted diseases[503], while similar powers can be exercised over those with illness such as cholera, malaria, tuberculosis, etc.[504] Some public health or safety legislations authorizes medical procedures without consent such as drawing a blood sample from the driver of a motor vehicle accident, to determine blood alcohol level.[505]

5.6. CONCLUSION

Society's increasing moral pluralism and the attempt to prevent personal values from being encroached upon are the important factor which has helped nurture the growth of the principle of autonomy.[506] No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference

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497 See, s.10, Public Health (Control of Diseases) Act, 1984.
498 Id. s.35
499 Id. s.37
500 M. Brazier & J. Harris, "Public Health and Private Lives" 4 *Med L Rev* 171(1996), p.175
501 s.17, Public Health (Control of Diseases) Act, 1984.
502 M. Brazier, J. Harris, "Public Health and Private Lives", 4 *Med L Rev* 171 (1996), p.177
503 Sexually Transmitted Disease Act 1956. See, s.6, 6A, 8-11, 15, 20.
504 The Health Act 1988, s.121.
505 The Traffic Act, 1909(NSW), ss.4F,4G(11) and the Traffic Act 1949 (Qld), s.16A(8),(10).
506 Irwin Kleinman, "The right to refuse treatment: ethical considerations for the competent patient", 144 *Can Med Assoc J* 1219 (1991), 1220.

of others, unless by clear and unquestionable authority of law.[507] The right to self-determination in health care is fundamentally sound. This right of self-determination and the need for consent to treatment must provide a patient the right to refuse treatment or else, the right would provide no practical benefit and is meaningless.[508] No doubt, patient autonomy should be one of the goals of treatment but not to the exclusion of all other considerations and that a model of treatment that maximizes the good or beneficence to the patient is the most appropriate. A strict adherence to the principle of autonomy can be problematic when patients appear to be cognitively competent but unable to make use of the information because of their emotional state. It is essential not to abandon these patients but to work closely with them in determining why they are making decisions that do not appear to be promoting their well-being. This exploration, combined with ongoing education by all the members of the health care team, is ethically desirable.[509]

Autonomy is the underlying concept of modern human rights law. The concept of privacy has roots in the principle of autonomy which requires individuals to be as free as possible from external forces so as to enable their actions to reflect as truly as possible their autonomous choices and intentions. Many American state courts have based a patient's right to self-determination on federal and state constitutional right to privacy.[510] The medical rights to privacy have been expressed as originating in fourth amendment privacy concerns, fourteenth amendment liberty concerns, and as an extension of the penumbral right to privacy recognized in *Griswold* v *Connecticut*.[511] The Arizona Supreme Court expressed the right to

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507 *Union Pac. Ry.* v *Botsford*, 141 U.S.250,251 (1891).

508 See e.g., *Barber* v *Superior Court*,195 Cal.Rptr.484,489 (1983). Two physicians were charged with murder and conspiracy charges after discontinuing treatment of a comatose patient at the request of the deceased's family, where there was virtually no chance of recovery. It was held that a physician's failure to continue treatment of a comatose patient at the request of the patient's family is not an unlawful failure to perform a legal duty and therefore is not punishable under the penal code.

509 Irwin Kleinman, "The right to refuse treatment: ethical considerations for the competent patient", 144 *Can Med Assoc J* 1219 (1991), 1222.

510 *In re Quinlan*, 355 A.2d 647, 663.

511 381 U.S. 479 (1965).

medical privacy most powerfully in *Rasmussen* v *Fleming*[512] when the court stated that 'an individual's right to chart his or her own plan of medical treatment deserves as much, if not more, constitutionally-protected privacy than does an individual's home or automobile'. Hence, the next chapter discusses the importance of privacy and medical confidentiality in protecting autonomy and self-determination of patients.

[512] *Rasmussen* v *Fleming*, 741 P.2d, 682. Rasmussen was suffering from degenerative neural muscular disease and an organic brain syndrome. Her mental and physical condition deteriorated to the extent that she was sustained through a nasal gastric tube. Mildred Rasmussen died of complications following pneumonia while her case was on appeal. The court found that none of the four possible state interests i.e., preservation of life, prevention of suicide, protection of innocent third parties, and preservation of medical profession's ethical integrity were predominant in Rasmussen's case and that, if a decision could not be made on the basis of what the patient would have wanted, then a decision could be made by a family member or guardian on the basis of the patient's 'best interests'. The Arizona Constitution provides that: 'no person shall be disturbed in his private affairs, or his home invaded, without authority of law'. It is to be mentioned here that the state constitutional provision normally was applied in a search and seizure context.