CHAPTER III
CONSENT AND INFORMED CONSENT: LEGAL SCENARIO
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3.1. INTRODUCTION

All kinds of medical treatment involve interference with human body. A doctor is required, as part of his duty of care to the patient, to explain what he intends to do, and the implication involved, in the way in which a responsible doctor in similar circumstances would have done, and if there is a real risk of misfortune inherent in the procedure, however well it is carried out, the doctor has a duty to warn of the risk of such misfortune^279.

Any therapeutic or investigative procedure without consent is technically an offence. It can be either under Tort (civil) or Criminal law^280. Under Civil law, a non-consensual interference in to body of a person can be either “assault” or “battery”. It comes under the heading “trespass to the person”.

3.2. CONSENT UNDER LAW OF TORT

Law of Tort uses the word ‘trespass’ to refer to the direct interference with a person’s body or liberty. In its original legal meaning it signified no more than ‘wrong’.^281 Trespass was so called from the name of the writ which commences it- writ of trespass.^282 The writ was intended to provide effective remedies for persons aggrieved by violent injuries to person and property^283. It was considered as a breach of king’s peace and used to be dealt by the king’s courts. In the course of time ‘trespass’ has got a wider meaning covering injuries to land, to goods and to persons.^284 As, its jurisdiction widened, the writ became popular as an instrument for protection against powerful malefactors.^285

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279 Chatterton v. Gerson [1980]1 BMLR 80 (QBD))
281 ROGERS supra note 35 at 97-98.
283 *Id* at 16
284 ROGERS supra note 35 at 97-123.
285 LAKSHMINATH & SRIDHAR ,supra note 282
Trespass to the person can be in three main forms, assault, battery and false imprisonment. All the three has a common element that it must be committed by direct means. The principle is that any direct invasion of a protected interest from a positive act is actionable as trespass subject to justification. If the invasion is indirect or from an omission as distinguished from a positive act, there could be no liability for trespass, though the wrong doer might have been liable in some other form of action. If the invasion is unintended, though direct and resulting from a positive act, there will still be no liability, if the conduct of the defendant was reasonable. However, liability for trespass arises even if it was reasonable, if the invasion was a foreseeable consequence. In Fowler v. Lanning, the plaintiff claimed damages for trespass to the person and it was alleged that the defendant shot plaintiff on a particular date at a particular place. Holding that the statement of claim did not disclose a course of action, DIPLOCK, J. expressed that trespass to person will not lie if the injury to the plaintiff, although the direct consequence of the act of the defendant, was caused unintentionally and without negligence on his part. And the onus of proving intention or negligence is on the part of the plaintiff.

3.2.1. Assault

Assault is an act of the defendant which causes the plaintiff reasonable apprehension of the infliction of a battery on him by the defendant. Assault does not require contact. Its essence is conduct which leads the plaintiff to apprehend the application of force. In majority cases assault proceeds battery. But there are cases where the plaintiff had no opportunity of experiencing any apprehension before the force is applied. Assault is a tort and a crime like battery, due to its tendency to breach the peace. In order to raise an action for assault, the plaintiff must prove that there was some gesture or preparation.

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286 Rogers supra note 35
288 Id at 255
289 (1959) 1 QB 426
290 Singh supra note 287
291 Rogers supra note 35
292 Id
which constituted a threat of force. The gesture or action must cause a reasonable apprehension of force. And assault must be intentional.\textsuperscript{293}

### 3.2.2. False Imprisonment

False imprisonment means the total restraint of a person’s liberty without lawful justification. Every restraint of liberty of one person by another is in law an imprisonment and if it is imposed without a lawful cause, it is false imprisonment. False imprisonment is a tort and it used to be followed with force or threat of force, it was regarded ,in early times as assault or battery.\textsuperscript{294} A mere restraint or obstruction of movement in one direction is not imprisonment and actionable as such. It is however a crime and actionable by reason of damage resulting from it.\textsuperscript{295}

### 3.2.3. Battery

Battery is the intentional application of force to a person without lawful justification. Battery need not be accompanied by a physical harm.\textsuperscript{296} The mere use of force is considered as unlawful on account of the insult to the dignity of the person and its tendency to cause a breach of peace.\textsuperscript{297} A battery includes an assault which is briefly stated is an overt act, evidencing an immediate intention to commit a battery. Physical contact is necessary to accomplish battery.\textsuperscript{298} In an action for battery the plaintiff must prove, first the use of force to him. It may be directly to his body, e.g., slapping, pushing, bringing an object in contact like, setting a dog or throwing a stone at him. It may also be to objects in contact with him, eg.touching his coat, upsetting the carriage on which he is seated or whipping a horse on which he is riding causing it to throw him off.\textsuperscript{299}

Battery requires actual contact with the body of another person, so seizing and laying hold of a person so as to restrain him,\textsuperscript{300} taking a person by his

\textsuperscript{293} LAKSHMINATH & SRIDHAR, supra note 282
\textsuperscript{294} Id
\textsuperscript{295} Section 339 of Indian Penal Code
\textsuperscript{296} LAKSHMINATH & SRIDHAR, supra note 282
\textsuperscript{297} Id at 49-54
\textsuperscript{298} SINGH supra note 287 at 256-275
\textsuperscript{299} SINGH supra note 287 at 256-275
\textsuperscript{300} Rawling v.Tull (1837) 3 M KW 28.
collar, causing another to be medically examined against his/her will are held to amount to battery. A physical contact with the body of the person or his clothing is sufficient to amount to ‘force’. There is battery if the defendant shoots the plaintiff from a distance just as much as when he strikes him with his fist. Similar is the case when defendant deliberately runs into the car in which plaintiff is sitting, shaking him up.

The use of force must be intentional and without lawful justification. Jostling another unintentionally in a crowd is not, but doing it deliberately will amount to battery. An injury inflicted by an instrument held in hand is not; nevertheless a strike by a missile is a battery. Throwing water on another is assault, and falling a drop upon him, will make it battery.

In the words of HOLT, C J, the least touching of another in anger is battery. However hostility as a test to distinguish battery from a legally unobjectionable contact will be too narrow. In practical situation an unwelcomed kiss is as much actionable as a blow which need not necessarily stem from ‘anger’. ROBERT GOFF L.J. said in Collin’s case that, quite apart from specific defenses such as lawful authority, bodily contact was not actionable if it was generally acceptable, in ordinary conduct of everyday life. It was held that battery involves a ‘hostile’ touching. However that hostility did not require ill will or malevolence. The central idea is that the interference must be ‘offensive’ in the sense that, it infringes the claimant’s right to be physically inviolate, to be ‘let alone’.

301 Wiffin v. Kincard (1807) 2 B & PNR 471
302 Latter v. Braddell (1881) 28 WR (Eng) 239
303 ROGERS supra note 35
304 Clark v. State, 746 So 2d 1237 (Fla.1999)
305 Cole v. Turner (1704) 6 Mod 149
306 SINGH supra note 287
307 Pursell v. Horn, (1832) 3 N & P 564, 8, A & E 602
308 Cole supra note305
309 ROGERS supra note 35
310 Collins v. Wilcock [1984] 1 W.L.R. 1172
311 ROGERS supra note 35
312 Id


3.2.4. Consent and Battery

Where there is consent, there is no battery and the same is true where the plaintiff, though not in fact consenting, so conducts himself as to lead the defendant reasonably to believe that consent exists. Therefore, consent, expressed or implied is a lawful justification. It may be implied from the situation or relationship of parties e.g., friendly push or shaking hands. Subject to lawful authority, such as power of arrest, an adult of full understanding has an absolute right to the inviolability of his body and therefore has an absolute right to choose whether or not to consent for medical treatment.

It is battery to administer medical treatment to an adult, who is conscious and of sound mind, without his consent. If an adult person of sound person refuses to consent to a medical treatment, it should be adhered to even though it is not in the interest of the patient. There are defenses also such as situations of emergency where an urgent action is imperative in the interest of the patient, and because the patient is unconscious or for some other reasons consent cannot be obtained unless too late. Necessity also is a defence. In case of patients who are in a persistent vegetative state, subject to stringent requirements of both law and medical profession, consent may not be insisted upon.

3.2.5. Consent Under Criminal Law

Under the criminal law, consent can be a defense, if given by an adult who is sound mind. Physical interference without consent in the absence of legal authority constitutes an offence. This concept is derived from the maxim *volunti non fit injuria* (he who consents suffers no injury). It is founded on the two prepositions, (a) every person is the best judge of his own interest and (b)
no man will consent to what he thinks hurtful to himself. Under civil law, no suit can be brought in consequence of anything done or arising of what is done with the consent of the person complaining it. Consent is a complete answer in such suits. In criminal law it is different. Acts are punished as crimes, because it is in the interest of the society that they should be prevented. Consent of the immediate sufferer is immaterial, if the injury to society remains.

3.2.6. Use of Criminal Force

Intentionally using force to any person, without that person’s consent, in order to or intending to commit any offence is use of criminal force. Use of criminal force will be aggravated in the light of the person on whom force is used (e.g. public servant or woman) or other circumstances. When it is a criminal offence, the indictments are framed under the penal code. Use of force must be intentional. The definition of criminal force contemplates the force being used against a person and not against a matter or a substance. The force must be used without consent. Mere submission by one who does not know the nature of the act done cannot be consent. The force must have been used with the intention of committing an offence or to cause or knowing it to be likely to cause injury, fear or annoyance to the person to whom the force is used. If the use of force results in a wound, then the offence will be termed “hurt” or “grievous hurt” be either “assault” or “battery”. In case of death, various categories of homicide become relevant in India.

3.2.7. Using Criminal Force

In a charge of assault, consent can never be a defense when the alleged assault consists of an unlawful act. Sections 87 to 92 of the Indian Penal Code are significant in this respect. These sections are significant in determining the

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323 Id
325 Bakshi, supra note 321
326 Thakkar, supra note 324
question how far consent is necessary and sufficient to legalize invasive action.\textsuperscript{327}

A person above 18 years of age can give valid consent to suffer any harm, which may result from an act not intended or not known to cause death or grievous hurt\textsuperscript{328}. Similarly an act is lawful, if it is done with valid consent of an adult, in good faith for his/her benefit, not intending to cause death\textsuperscript{329}. An example is given about a surgeon operating his patient with his consent in good faith, knowing that such an operation is likely to cause patient’s death. Also, a guardian can give valid consent to inflict any harm that may result from an act, not intended or not known to cause death, done in good faith and for the benefit of a child below 12 years of age or an insane person\textsuperscript{330}. At the same time law is very clear about a consent not being valid, when it is given under fear or misconception\textsuperscript{331}. An act which is independently an offence will not be justified, just because it is done with the consent of the sufferer\textsuperscript{332}. However, criminal law system protects, actions done in good faith, for the benefit of the sufferer, even without consent, in case of emergency. In criminal procedure, it shall be lawful for a registered medical practitioner, acting at the request of a police officer not below the rank of sub-inspector, to make an examination of the person arrested, and to use such force as is necessary for that purpose.\textsuperscript{333} Pain or torture for the purpose examination is allowed by law\textsuperscript{334}. Even reasonable force can be used even though it may cause discomfort\textsuperscript{335}. Examination shall include the examination of blood, sweat, hair, finger nails etc., as in the case may be. DNA evidence is now a predominant forensic technique for identifying criminals when biological tissues are left at the scene of crime.\textsuperscript{336} A criminal court can make a direction for blood test to be taken by taking blood sample of

\textsuperscript{327}Bakshi, supra note 321  
\textsuperscript{328}Sec 87 IPC  
\textsuperscript{329}Section 88 of IPC  
\textsuperscript{330}Section 89 of IPC  
\textsuperscript{331}Section 90 of IPC  
\textsuperscript{332}Section 91 of IPC  
\textsuperscript{333}Section 53 of Cr.P.C.  
\textsuperscript{335}Ananth Kumar v. State of A.P.,1977 Cr.L.J 1797 (A.P)  
\textsuperscript{336}CHANDRACHUD & MANOHAR, supra note 334
the complainant, accused and of the child. But an order to submit to blood test which involves insertion of needle in the veins of a person, is an assault, unless consented to. It would need express statutory authority to require a person to submit to it. This is based on the fundamental principle that human body is inviolable and no one can prick it. Where a court makes a direction for blood test and the accused fails or refuses to comply with it, the court can use such failure or refusal as corroborative evidence against him.337

3.3. CONSENT UNDER CONTRACT LAW

Section 13 of the Indian Contract Act lays down that two or more persons are said to consent when they agree upon the same thing in the same sense (consensus ad idem)338 And Section 11 states that every person who is of the age of majority is competent to contract. According to the Indian Majority Act339 every person attains the age of majority on his completing the age of 18 years.340 Consent is free when it works without obstacles to impede its exercise. Consent is said to be free when it is not caused by co-ercion, undue influence, fraud, misrepresentation or mistake. Consent can be regarded as informed when it is an act of reason accompanied with deliberations of a mind which knows right from wrong, good and evil and it postulates an active will on the part of the person giving consent to permit the doing of the act complained of with full knowledge of the act that is being done and the rights and obligations of the parties involved in the commission of the act. Where Consent was given on the strength of a representation, which, when made, was not intended to be rally acted upon, it was held to have been obtained upon a misrepresentation.341

337 CHANDRACHUD & MANOHAR, supra note 334
339 Sec 3 (1)
340 Mathiharan, supra note 280
3.3.1. **Duty of Disclosure**

In common law, there is no general duty of disclosure of material facts before the contract is being made.\(^\text{342}\) For example, a bank has no duty to inform its customers that a more attractive rate of interest is available on a different account. This reflects a major difference between common law and civil law, since in most civil law systems a party who deliberately does not disclose material facts to the other party may be liable for fraud.\(^\text{343}\)

3.3.2. **Contracts of ‘Uberrimae Fidei’**

Contracts of *uberrimae fidei* are those of utmost good faith. They may be avoided unless there has been a full disclosure of all material facts. In certain classes of contracts, one of the parties is presumed to have means of knowledge which are not accessible to the other. The party who is presumed to have the information is therefore bound to disclose all information which is likely to affect the judgment of the other party. Contracts of insurance are of this type. In another case, certain contractual relations are not purely commercial in nature, but one of trust and confidence and one of dependence which imposes upon the party in whom confidence is reposed, a duty to make disclosure.\(^\text{344}\)

3.4 **Consent and Medical Negligence**

A doctor’s duty of reasonable care involves giving the patient, a description of his conditions and appropriate course treatment including the risks.\(^\text{345}\) If there is a probability of the treatment producing results, which are harmful to patient, those factors must be weighed by the doctor, before he recommends the treatment. The patient is entitled to consider and reject the treatment and for that purpose, it is necessary to understand doctors’ advice and the possibility of harm resulting from the treatment including surgery.\(^\text{346}\) In the medical negligence


\(^{343}\) *Id.*, quoting Lando and Beale, Principles of European Contract Law

\(^{344}\) Beatson, supra note 342


cases, negligence usually means that diagnosis, advice or treatment was carried out carelessly or improperly or without adequate technical skill, and the injury which resulted was avoidable with proper diagnosis, advice or correctly performed treatment\(^{347}\). In the cases under consideration, the injury arises not from an inadequately performed medical procedure but from a risk inherent in a treatment adequately carried out, a risk known to the doctor but not disclosed to the patient.\(^{348}\) Harm is caused by the inadequate information because, had adequate information been given, the patient would not have agreed to the treatment which resulted in the injury.\(^{349}\) Thus, a claim in negligence requires the plaintiff to prove that the doctor's general duty of care includes an obligation to inform of certain risks, a breach of that duty by not informing of those risk and harm caused by that breach because injury resulted from a procedure or treatment the patient would not have agreed to had the true risk been disclosed.\(^{350}\) The significant question is whether ‘the doctor, in the disclosure or lack of disclosure which has occurred, acted reasonably in the exercise of professional skill and judgment or not?’ In determining the what information must be given, variables such as the age of the patient, the mental, emotional and physical condition of the patient, the physician's judgment as to the treatment needs of the patient, the patient's questions or denial of desire for information, the nature of the risk, the seriousness of harm and its likelihood of occurrence, and the nature of the proposed medical procedure, are included.\(^{351}\)

In Allan’s\(^{352}\) case, the anesthetic was administered by an injection into vein in patients left arm. The drug leaked into the tissue of the arm and the needle slipped during operation. The patient suffered sudden and unexpected reaction. The doctor was not held liable in negligence, since such mode of administration of anesthetic drug was an accepted medical practice. Moreover such leakage was an expected risk of the procedure. But the doctor was held liable for battery,

\(^{348}\) Mack supra note 347
\(^{349}\) Id
\(^{350}\) Id
\(^{351}\) Id
since the patient expressly prohibited the doctor from administering anesthetic to her left arm. This decision made a loud statement that the physician who does not care to obtain consent of the patient will be liable even if he undertakes a practice which is accepted by his own professional body. However the decision was reversed by the Court of appeal on the ground that the patient has not pleaded battery. In a resembling case, a woman consulted a doctor for an aliment which required minor gynecological surgery. The surgeon, while performing that surgery discovered that the woman’s womb was ruptured. He sterilized her there and then. The patient had not agreed to sterilization. The doctor was held liable for unauthorized interference with patient’s body.\textsuperscript{353} The concept of patients autonomy suggest that a competent adult has every right to choose the mode of treatment and reject one even if it may appear to be wrong in the eyes of the physician.\textsuperscript{354}

3.4.1 Elective Surgery

The law expects a doctor to inform the patient about the inherent risks involved in the medical intervention. Therefore he has to do this for obtaining consent of the patient in such a way that a reasonable physician would have done in his situation. The common risks involved in a surgery which is essential for continued good health may not be necessary. But in case of surgeries which are not essential, such as sterilization, cosmetic surgeries, the physician is expected to inform about the common risk also\textsuperscript{355}. The liability of physicians in case of absence of disclosure of information will be determined according to the set standards of negligence in the accepted medical practice.\textsuperscript{356} In Manual Ben’s case\textsuperscript{357} the patient had undergone dilation and evacuation operation for termination of pregnancy. The surgeon who conducted the operation removed uterus for saving patients life. It was held by the state commission that the surgeon has acted in such a way that any responsible person of his profession would have performed in his position. The doctor was held not liable as it was

\textsuperscript{353} Devi v. West Midlands AHA, (1980)7 C. L. 44.
\textsuperscript{354} BAG supra note 345
\textsuperscript{355} Vidoeto v. Kennedy (1980) 107DLR (3d 612), BAG supra note 345
\textsuperscript{356} Cold v. Haringey Health Authority[1988]QB 481(r.k.Baug)
\textsuperscript{357} Manjulaben Patel v. Harshida Patel 1997(3) CPR 264
an emergency surgery to save patients life. The Courts in India have held surgeon liable for performing sterilization during caesarian section without consent, when it is not to save the life of the mother or in an emergency. It was held by State Commission, Tamil Nadu, that the consent given by the patient for abdominal hysterectomy has no validity, since she is not capable of understanding the medical terminology, in a situation, where such surgery was not a necessity.

3.4.2 Right to Refusal

The patient has right to protect his own body from outside interference. The tort of battery establishes the concept that any non-contentious touch which is harmful or against the reasonable sense of dignity is actionable. When a medical man advances the plea that a patient refused to follow his prescription for treatment or advice for surgery, the duty is on the physician to prove that the absence of treatment or non-performance of surgery was on account of patients refusal. A practical question that may arise is whether (a) it is for the patient to prove that he did not agree to the medical or surgical procedure in question, or (b) whether it is for the doctor to prove that the patient gave his consent. A High Court judge in England has taken the former view. Indian courts have taken different views based on facts of each case. No doubt, consent may be implied and therefore a court may presume that up to a certain limit, implied consent was given. But beyond that, specific proof may be required in each case. In India, the burden of proof lies upon the doctor to justify an action which would be illegal in the absence of consent.

In 1992, it was held in England, that the court would exercise its inherent jurisdiction to authorize the surgeon to carry emergency caesarian section in order to save the life of an unborn child contrary to patients belief and refusal.

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358 Janaki Kumar v. Sarafunnisa 1999(3) CPR 472(Ker)
359 Lakshmi Rajan v. Malar Hospitals 1997(3) CPR 90 (Chennai)
360 BAG supra note 345
361 Thomas v. Elisa AIR 1987 Ker. 52
363 Sections 101 to 105 Indian Evidence Act, 1872
364 Re. S [1992] 4 All ER 671
But later in 1997, in another case\textsuperscript{365}, a child was born with a defective liver. Doctors were of the opinion that with a liver transplant, this can be rectified and it is most probable that the child will have many years of normal life. The mother of the child refused to give consent for the treatment. Under the wardship jurisdiction the judge gave permission to perform the operation. Reversing this decision the Court of Appeal held that, the mother being the natural guardian her views were relevant and the trial judge erred in giving a permission overriding the parent’s refusal.

When a surgeon or medical man advances a plea that the patient did not give his consent for the surgery or the course of treatment advised by him, the burden is on him to prove that the non-performance of the surgery or the non-administration of the treatment was on account of the refusal of the patient to give consent thereto. This is especially so in a case where the patient is not alive to give evidence. Consent is implied in the case of a patient who submits to the doctor and the absence of consent must be made out by the person alleging it\textsuperscript{366}.

### 3.4.3 Waiver

An attitude of the patient or parents/guardian, where they wish not to have information that might unduly distress them, and leave the decision on the physician must be honored and this is called ‘waiver of consent’. Indian patients who are poor, underprivileged, with low education levels have blind faith in the doctors and believe the best of treatment will be offered to them or their child. Such waiver of consent should be documented in medical records, and preferably should be in the form of signed proforma\textsuperscript{367}.

### 3.4.4 Minor’s Consent

Section 3 of Indian Majority Act, 1875, sets the age of majority as 18 years in India. Therefore a person who has not completed 18 years is minor. The age of consent is bound by legal definitions and within the context of the Indian law;

\textsuperscript{365} Re.T(a minor)( wardship: medical treatment) [1997]1 All ER 906(CA)
\textsuperscript{366} Thomas v. Alisa AIR 1987 Ker 52
\textsuperscript{367} Kaushik et al., Informed Consent in Pediatric Practice, Indian Pediatrics, Volume 47 December 17(2010).
there are two schools of thought. Indian Penal Code states that consent by intoxicated person, person of unsound mind or a person below twelve years of age is invalid. According to the Indian Contract Act of 1872 – a competent person of sound mind who has attained the age of majority that is 18 years can only legally enter into a contract. Then the question is about the validity of consent given by a person who is above 12 year and below 18 years. As per Hindu law, the natural guardian or the guardian appointed by the court has authority to give consent for medical treatment, including surgery on behalf of the minor. In Common-law natural guardian is authorized to do all acts which are necessary or reasonable in the best interest of the minor. The child’s power to give consent for medical treatment is concurrent to that of the parents and a parental consent may render lawful treatment to which the child objects, though no doctor can be compelled to administer treatment and in deciding whether or not to do so he will be influenced by the child’s wishes. When the child has the capacity to give valid consent and does so, parent’s objection to the treatment will not invalidate child’s consent.

3.4.5 MEDICAL TERMINATION OF PREGNANCY

The circumstances under which Medical Termination of Pregnancy (MTP) can be performed, the places where it can be conducted, the qualifications, experience and training of personnel who can conduct the MTP, the conditions for approving places, and recording and reporting procedures, etc., are specified under the Medical Termination of Pregnancy Act, 1971, and the MTP Rules and Regulations of 1975.

A girl under 18 years of age cannot give valid consent to undergo medical termination of pregnancy. Pregnancy of a minor cannot be terminated except with written consent of her guardian. Parental consent is essential in case of a

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368 Section 90 of IPC
369 Section 4,24 of Guardian and Wards Act,1890, Section 4 of Hindu Minority and Guardianship Act 1956
370 R,Re [1992] Fam. 11 ROGERS supra note 35.at 104-121
371 R,Re [1993] Fam.64 ROGERS supra note 35.at 104-121
372 Section 4(a) of Medical termination of Pregnancy Act,1971
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minor or a lunatic, and the provision ensures that no pregnancy shall be terminated without the consent of the woman.

In Gilliks case\(^{373}\) it was held that a minor can also give valid consent, if minor is capable of sufficient intelligence and power of understanding about the proposed procedure. This can be read along with the fact that In India, all persons are considered competent to testify, unless the Court considers that they are prevented from understanding the questions put to them, or from giving rational answers to those questions, by tender years, extreme old age, disease, whether of body or mind, or any other cause of the same kind\(^{374}\). A child witness is allowed to testify if he is capable of understanding the questions put to him and answer rationally. But the capability is subjective and is a matter of fact to be determined based on the evidence produced before the court\(^{375}\). It may be mentioned that according to recent trends, the wishes of a child who is below 18 years of age but who is mature enough to understand such matters have to be taken into consideration.\(^{376}\) In V. Krishnan’s case\(^{377}\), the Madras High Court held that a father cannot compel his daughter of 16 years to undergo abortion. It has to be understood that a person above 12 years of age can consent to medical/surgical/dental treatment, if it is intended for their benefit and undertaken in good faith.\(^{378}\)

In case of emergency, when parents/guardians are not available to consent, a person in charge of the child like principal or school teacher can consent for medical treatment (\textit{loco parentis})\(^{379}\). For children who are orphans or unknown or street children, the court is appointed as a guardian and any procedures/treatment requires court permission.\(^{380}\) An act done in good faith for benefit of a person less than 12 years of age by consent, either express or

\(^{373}\) Gilick v. West Norfolk and Wisbeeli AHA. (1985) 3 All.E.R. 402
\(^{374}\) Section 118 of Indian Evidence Act.,1872
\(^{375}\) Section 4 of Guardian and Wards Act,1890, Section 4 of Hindu Minority and Guardianship Act 1956 Mathiharan, supra note 280.
\(^{376}\) Bakshi, supra note 321
\(^{377}\) V. Krishnan v. I.G.Rajan, (1994) Law weekly (Crim.) 16
\(^{378}\) Kaushik et al., supra note 367
\(^{379}\) Kaushik et al., supra note 367
\(^{380}\) Id
implied, by the guardian or other person having lawful charge is not an offence by reason of any harm. This exception is not available if there is an intention to cause death or grievous hurt. In emergency situations, where there are no guardians/parents from whom it is possible to obtain consent, one can proceed to save the life of the child\textsuperscript{381}.

### 3.4.5 Blood Test And Transplantation of Organs

A person cannot, in the absence of statutory authority, be subjected to blood tests. In Gautama Kundu’s case\textsuperscript{382}, it was held that no one can be subjected to blood test against his wishes for determining paternity and the court has no such power to order blood test where no statute exists to give such authority. Courts in India cannot order blood test as a matter of course. Unlike the English law in India there is no special statute governing this. Neither in the Criminal procedure Code nor the Evidence Act empowers the court to direct such a test\textsuperscript{383}. In the case of persons accused of offences, physical examination of the body including pathological tests, have been authorized.\textsuperscript{384} Transplantation means the grafting of tissues taken from one part of the body to another part or another individual.\textsuperscript{385} In order to curb the unethical and uncontrollable trade in human organs, the Transplantation of Human Organs Act, 1994 was passed by the Parliament. Its objective is to provide for the regulation of removal, storage and transplantation of the human organs for the therapeutic purpose and for the prevention of commercial dealings in human organs. Removal of any organ for therapeutic purposes from a living person is authorized.\textsuperscript{386} It is required that a live donor of human organ must have given his voluntary consent to transplantation of an organ from his body.\textsuperscript{387} If the person is above 18 years, conscious and of sound mental health his/her own consent is required for removal of organs from his/her body. Therefore, it is

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\textsuperscript{381} Section 92 IPC
\textsuperscript{382} Goutam Kundu v. State of West Bengal 1993 AIR 2295
\textsuperscript{383} Goutam Kundu supra note 382
\textsuperscript{384} Section 53, Code of Criminal Procedure, 1973
\textsuperscript{385} LILY SRIVASTAVA, LAW & MEDICINE (2010)
\textsuperscript{386} Section 3 The Transplantation of Human organs Act, 1994
\textsuperscript{387} Section 3 (1) of The Transplantation of Organs Act (42 of 1994)
illegal to remove of organs from the body of a person of less than 18 years even with his/her consent.\textsuperscript{388} The Act necessitates that,\textsuperscript{389} the donor must be not less than 18 years and must voluntarily authorize. Most importantly, consent of the donor must be informed.

### 3.5 Exceptions

In \textit{Thomas v. Alisa},\textsuperscript{390} the High Court observed that:

As a general rule, medical treatment, even of a minor nature, should not proceed unless the doctor has first obtained the patient's consent. This consent may be expressed or it may be implied, as it is when the patient present himself to the doctor for examination and acquiesces in the suggested routine. The principle of requiring consent applies in the overwhelming majority of cases, but there are certain circumstances in which a doctor may be entitled to proceed without this consent -- firstly, when the patient's balance of mind is disturbed, secondly, when the patient is incapable of giving consent by reason of unconsciousness; and, finally, when the patient is a minor.

The following are such cases where law allows the doctor to act without consent.

#### 3.5.1 Mentally ill persons

Mentally ill person means a person who is in need of treatment for any mental disorder, other than mental retardation.\textsuperscript{391} People with mental disorders are particularly vulnerable to abuse and violation of their rights.\textsuperscript{392} There are more excuses for violation of individual autonomy and forced treatment due to the very absence of mental ability. Mental Health Act, 1987 is silent regarding the consent for treatment, and the method to be adopted when a severely ill patient refuses well established treatments like medication or modified electroconvulsive therapy.\textsuperscript{393} Hospitals at their level try to evolve some uniform

\textsuperscript{388} Chaturvedi supra note 338  
\textsuperscript{389} SRIVASTAVA supra note385  
\textsuperscript{390} AIR 1987 Ker 52  
\textsuperscript{391} Section 2(1) of Mental Health Act,1987  
\textsuperscript{393} Math et al., Mental Health Act (1987): Need for a paradigm shift from custodial to community care 246-249 Indian J Med Res 133 (March 2011).
standards for taking decisions on behalf of a patient unable to consent. One suggested method is to obtain the opinion of two psychiatrists independently and also the consent of the hospital RMO or superintendent who acts as a surrogate guardian.\textsuperscript{394}

\textbf{3.5.2 \textsc{Emergency Treatment}}

In case of emergency, the well-being of the patient is paramount and medical rather than the legal considerations come first.\textsuperscript{395} Generally it is essential to obtain consent before any treatment is administered. However, there is an important exception to the rule. In cases of emergency a patient may be unable to give consent, in such cases a substitute decision maker, can give the consent. If however such a person is not on the scene, then it is the duty of the doctor to do what is essential to save life even without consent.\textsuperscript{396} A doctor can give treatment, including surgery to adult patients who are unable to give consent, in an emergency, provided such treatment is performed in the best interest of the patient. Similarly in a life threatening situation the doctors need not consult the parents of minor patients.\textsuperscript{397} The doctor has the authority to perform any mode of treatment as is necessary, in the best interest of the patient, in an emergency situation whether it is based on ‘implied consent’ or ‘agency by necessity’. Section 92 of the IPC offers legal immunity to a registered medical practitioner to proceed with appropriate treatment even without the consent of the patient in an emergency when the victim is incapable of understanding the nature of the treatment or when there are no legal heirs to sign the consent. If the patient is conscious and refuses treatment without which that person might endanger his/her life, then the surgeon can inform the judicial magistrate and get the sovereign power of guardianship over persons under disability (\textit{parens patriae}).\textsuperscript{398} In a case, the surgeon did not explain the hazards of chloroform anesthesia before taking consent of the patient for operation of appendicitis. Finding the appendix to be normal, he proceeded to remove the gallbladder

\begin{itemize}
\item \textsuperscript{394} Math et al supra note 393
\item \textsuperscript{395} Mathiharan, supra note 280
\item \textsuperscript{396} Chaturvedi supra note 338
\item \textsuperscript{397} Marshall v. Curry (1993)3 DLR 260
\item \textsuperscript{398} Charan Lal Sahu v. Union of India, (AIR 1990 SC 1480)
\end{itemize}
without consent. The surgeon was held negligent for risking the ill effects of the patient under chloroform. Since this surgery was neither emergency nor in the best interest of the patient.\textsuperscript{399}

At the same time, conducting an emergency surgery is a duty of the surgeon. A surgeon who failed to perform an emergency operation must prove with satisfactory evidence that the patient refused to undergo the operation, not only at the initial stage, but even after the patient was informed about the dangerous consequences of not undergoing the operation\textsuperscript{400}.

\section*{3.6 Informed Consent and Medical Treatment}

A complex situation arises where a patient agrees to a proposed treatment or procedure, but claims that the information which led to the agreement was inadequate. Such a claim lies in negligence, not battery, and is based on the argument that, by failing to disclose certain information, the physician has breached a duty of care to the patient. This claim of lack of informed consent does not deny the existence of consent; such a claim challenges the adequacy of the information on which the patient's agreement was based\textsuperscript{401}.

Taber's Cyclopedic Medical Dictionary defines informed consent as:

\begin{quote}
Consent that is given by a person after receipt of the following information, the nature and purpose of the proposed procedure or treatment, the expected outcome and the likelihood of success and the risks. The alternatives to the procedure and supporting information regarding those alternatives and the effect of no treatment or procedure, including the effect on the prognosis and the material risks associated with no treatment. Also included are instructions concerning what should be done if the procedure turns out to be harmful or unsuccessful.
\end{quote}

\textsuperscript{399} Ram Behari Lal v. JN Srivastava AIR 1985 MP 150, ACJ.
\textsuperscript{400} Thomas v. Alisa AIR 1987 Ker 52
\textsuperscript{401} Mack supra note
\textsuperscript{402} K K Aggarwal, \textit{Real Consent and not Informed Consent Applicable in India}, Indian Journal of Clinical Practice, Vol. 25, No. 4, September 2014. \url{http://medind.nic.in/iaa/t14/i9/iaat14i9p392.pdf}. Last visited on 29-08-2016 at 20.05
3.6.1 INFORMED CONSENT

Informed consent is an ongoing process rather than a mere signed form. It must involve willingness to listen and discuss patients problems concerned with the proposed treatment. The following are essential ingredients of Informed Consent.

- Disclosure of Information

Disclosure of information includes the following: 1. Doctor should explain to his patient the exact nature of the disease or the ailment. 2. Patient must be clear about the need for the treatment and the nature of the procedure along with the expectation form the line of treatment recommended along with the likely chances of success. 3. Patient must be made aware of the alternative forms of treatment available with benefits and reasonably foreseeable adverse effects/risks and complications involved in both the proposed and alternative procedure. 4. The existence of a right to refuse all of them and the medico legal consequences of such refusal. 5. The right to choose between proposed and alternative procedure must be exercisable and sufficient time must be given.

- Free and Voluntary Decision

Patient's consent must be voluntary and free from coercion, force and misrepresentation of facts. Consent to be legally valid must be intelligent, informed and voluntary and should be taken freely and exclusively by the patient. Nobody is authorized to give consent on behalf of the patient (with few exception discussed later).

- Capacity to decide

This forms the most important aspect of informed consent. A competent person who is able to understand the nature of the act and logical consequences of the act should give consent. The person should be mature enough to understand,

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404 Patil & Anchinmane supra note 404
analyze and assess the risks and benefits associated with such form of proposed
treatment and accept the responsibility for the informed consent given to such
treatment. A competent person must fulfill following criteria’s, 1. He should be of sound disposing mind. 2. He should be legally competent to do so. 3. He should have proper reasoning for his decision. 4. He should be able to understand the implications of his consent. 5. He should be at least 12 years of age. 6. The informed consent will be legally valid when all the above mentioned components of informed consent are met.

An informed consent in broad terms is an agreement by and between the patient or its legal guardian and the consulting doctor confirming that the patient or the guardian has been informed and understood about the disease or the condition, procedure planned, associated risk and complications, prognosis, alternative treatment available and other relevant information by the doctor and the patient agree upon them voluntarily, unbiased and under physical and mental state enabling him to give the consent. The above description of an ideal consent clearly indicates three key requisite for this document to be valid. First, a consent should be voluntary, unbiased and given by the patient in free will. Secondly, it should be informed i.e. the patient or the subject prior to consent should be well informed in detail about the procedure, associated benefits, risk and complications and alternative treatment options available. The patient should be in capacity, physically and mentally to give the consent for the treatment or the procedure. Hence, consent can be considered as an agreement of mutual understanding for the services by the doctor and the patient as the consumer under Consumer Protection Act. Informed consent is the continuous process of providing the patient or, in the case of a minor or incompetent adult, the custodial parent or legal guardian with relevant information by doctor regarding diagnosis and treatment needs so that an

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405 Patil & Anchinmane supra note 404  
406 Id  
408 Id
educated decision regarding consent for treatment can be made by the patient custodial parent/legal guardian.⁴⁰⁹

### 3.6.2 IMPLIED CONSENT

Quite often a physician undertakes treatment on the basis of consent, which is implied either by the words or behavior of the patient or by the circumstances under which treatment is given.⁴¹⁰ An implied consent is a consent which is not written, that is, its existence is not expressly asserted still it is legally effective. In implied consent, a patient indicates his consent by the behavior and conduct.⁴¹¹ It implies consent to in a general sense. This is the most common form of consent seen in medical practice. But such type of consent is generally restricted to general and common procedure of medical examination. Beyond basic procedures it is necessary to take a full expressed informed consent.⁴¹²

### 3.6.3 EXPRESSED CONSENT

In expressed consent, a patient specifically expresses his free consent to a physician to undertake diagnostic or therapeutic treatment. It is in distinct and explicit language. This may be expressed either verbally or in writing after having the patient informed about all the aspects of the diagnostic and therapeutic procedure. When the patient conforms verbally to a specific diagnostic or therapeutic procedure it is called as oral or verbal expressed consent and when he gives it in writing it is called as written expressed consent. Both the forms of expressed consent are accepted in the court of law as proof of consent. It is the written expressed consent, which has more value, as it is a permanent record.⁴¹³ It is a must in any examination beyond routine physical

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⁴¹¹ Chaturvedi supra note 338

⁴¹² Patil & Anchimiane supra note 404

⁴¹³ Id
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Examination. Expressed consent must conform to the doctrine of informed consent to be legally acceptable.\footnote{Patil & Anchimane supra note 404}

For relatively minor examinations or therapeutic procedures, oral consent is employed. But this should preferably be obtained in the presence of a disinterested party. Oral consent, where properly witnessed, is as valid as written consent, but the latter has the advantage of easy proof and permanent form\footnote{Chaturvedi supra note 338}. Consent may be confirmed and validated adequately by means of a suitable contemporaneous notation by the treating physician in the patient’s record.\footnote{Chaturvedi supra note 338} Express written consent should be obtained for all major diagnostic procedures, general anesthesia, for surgical operations, intimate examinations, and examination for determining age, potency, and virginity and in medico-legal cases. It should be obtained when the treatment is likely to be more than mildly painful, when it carries appreciable risk, or when it will result in diminishing of a bodily function \footnote{Dhingra C & Anand R, Consent in Dental Practice: Patient’s Right to Decide. Oral Hyg Health ,Vol.2 Issue.2.(2014). http://www.esciencecentral.org/journals/consent-in-dental-practice-patients-right-to-decide-2332-0702-2-129.pdf. Last visited on 29-08-2016 at 20.30}

3.7 MEDICAL CONSENT-LAW IN USA

The evolution of Informed Consent as a legal doctrine in America was based on the need to extend civil liability of medical practitioners as well as to promote patient’s rights. This concept is explained in Mohr v. Williams, one of the earliest reported cases in this area.\footnote{95 Minn. 261, 104 N.W. 12 (1905), See Martin R. Struder, The Doctrine of Informed Consent: Protecting the Patient's Right to Make Informed Health Care Decisions, 48 Mont. L.Rev. (1987).} In this decision which dates back to 1905, physician obtained consent to operate on one ear, but after the patient had been anesthetized, on a re-examination, he has decided to operate on the other ear. Patient sued for an unauthorized touching though operation was successful. The court made it clear, “If the operation was performed without patient’s consent,
and the circumstances were not such as to justify its performance without, it was wrongful; and, if it was wrongful, it was unlawful.”\textsuperscript{419}

However patient’s right to self-determination was considered to be established in the historic decision of \textit{Schloendorff v. Society of New York Hospital}\textsuperscript{420} which came in 1914 in which Justice Cardozo made the emphatic statement:

> 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.

This formed the fundamental principle of medical consent in US\textsuperscript{421}. There was a shift in the focus in later years from authority of doctor to the adequacy of disclosure of information.\textsuperscript{422} The word ‘informed consent’ was first used in therapeutic practice in the landmark case of \textit{Salgo v. Leland Stanford Jr. University Board of Trustees}\textsuperscript{423} in 1957. In this case, Martin Salgo brought his physicians to court for their negligence and failure to warn him of the risk. Justice Bray ordered that physicians had an explicit duty to disclose certain forms of information and then to obtain the consent of their patient. The judgment discussed the question of sufficient information for obtaining consent, bringing focus to informed consent and the need to respect patient free choice. The doctrine of informed consent, as used now is thus attributed to this case.\textsuperscript{424} The Judge has set it clear while holding, “A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the

\textsuperscript{420} 211 N.Y. 125, 105 N.E. 92 (1914).
\textsuperscript{423} Struder supra note 418
\textsuperscript{424} Struder supra note 418
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proposed treatment.”

Later in Cobbs v. Grant in 1972, it was observed, “When the patient consents to certain treatment and the doctor performs that treatment but an undisclosed inherent complication with a low probability occurs, no intentional deviation from the consent given appears; rather, the doctor in obtaining consent may have failed to meet his due care duty to disclose pertinent information.”

By this time, eclipsing intervention without permission, omission of duty to disclose, came to the forefront in malpractice litigation. Cases earlier tried as battery eventually been evaluated as informed consent claims using negligence law. It established disclosure as the duty of physician.

The reasonable physician standard was first articulated in 1960 by the Kansas Supreme Court in Natanson v. Kline. In Natanson, the plaintiff had consented to radiation therapy after a mastectomy, and was injured by the radiation. She initiated a suit alleging that her physician did not disclose the risks of radiation therapy. The Court ruled that her consent was legally inadequate because of the absence of an adequate disclosure.

The reasonable physician standard presumes that, physician knows the best and what is reasonable to medical men is in the best interest of the patient. “[The physician] was obligated to make a reasonable disclosure to the [patient] of the nature and probable consequences of the suggested or recommended ... treatment, and he was also obligated to make a reasonable disclosure of the dangers within his knowledge which were incident to, or possible, in the treatment he proposed to administer.”

The District of Columbia Circuit Court was the first to articulate a patient-oriented standard of disclosure in a 1972 case, Canterbury v. Spence. In

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426 Cobbs v. Grant, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).


429 Id supra note 418

430 Id

Canterbury, a nineteen-year-old boy underwent surgery for a herniated disc following which, he was paralyzed. He took his physician to the court for the failure to disclose the risk of paralysis before performing the surgery. The court stated that the scope of the required disclosure must include risks that the patient views as material. Doctrine of informed consent was defined in this judgment as the right to be informed of material risks inherent in, and alternatives to, proposed medical procedures. It was held that “true consent to what happens to one's self is the informed exercise of a choice, and that entails the opportunity to evaluate knowledgeably the options available and the risks attendant upon each”. The Canterbury court observed that:

The physician's duty to disclose arose from three almost axiomatic considerations. First, every human being has a right to determine his or her own course of medical treatment. Second, real consent requires the informed exercise of choice, which in turn requires an opportunity to evaluate the options available and the risks associated with each. Third, the average patient has little understanding of medicine, and can only turn to a physician for advice.

Hence respect for the plaintiff's right of self-determination demands a standard set by law, rather than one which physicians set for themselves. Canterbury Principle established a new standard, requiring disclosure, tailor made for the special needs of each patient.

In Truman v. Thomas, a patient was advised to submit to a pap smear. The patient did not do so and was later diagnosed with cervical cancer. The physician was sued on the grounds that he failed to inform the patient about the risks associated with not having the Pap smear performed. The court did not accept the defense that the doctor cannot force patient to undergo a diagnostic procedure. It was held that the physician had a duty to disclose the risks associated with not having the Pap smear because that information was material.

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433 Rathor et al supra note 420
434 Id
435 Id
436 Mathew Bennett, A history of informed consent, Psychotherapy Forum, Ventana centre for Psychotherapy(Last visited on 29-08-2016 at 21.50)
to her treatment. Thus, *Truman* increased the physician's responsibility by requiring disclosure of information even if they are normally considered to be common knowledge.\(^{438}\) And the principle got clarified in *Harnish v Children's Hospital Medical Center*, in 1982:

> We also recognize that there are limits to what society or an individual can reasonably expect of a physician in this regard. Medical matters are often complex. Recommendations of treatment frequently require the application of considerable medical knowledge gained through extensive training and experience… a physician owes to his patient the duty to disclose in a reasonable manner all significant medical information that the physician possesses or reasonably should possess that is material to an intelligent decision by the patient whether to undergo a proposed procedure.\(^{439}\)

Later judges, in various decisions, in number of different judicial forums had detailed discussion on the extent and dimension of this consent, practical difficulties in obtaining it, situations which will demand unilateral actions and doctors liability in case of patients refusal etc.\(^{440}\) Courts in US follow two different standards while evaluating the scope of information those physicians must disclose for consent to be informed, one is the physician-oriented and the other is patient-oriented. The physician-oriented standard adopts the reasonable physician's viewpoint of what information should be disclosed, while the patient-oriented standard adopts the patient's viewpoint. The patient-oriented viewpoint has gained acceptance, but the traditional, physician-oriented viewpoint is still the law in many states.\(^{441}\) Currently, the states are almost evenly split between two types of standards for informed consent – the physician-based standard, effective in 25 states, and the patient-based standard, effective in 23 states and the District of Columbia.\(^{442}\) However an empirical

\(^{438}\) supra Note 135


\(^{441}\) Douglas A. Grimm supra note 431

study published in Journal of Empirical Legal Studies, Stoddert et al. (2007), shows significant difference in impact as the states with patients’ standard are having more decisions favoring plaintiff as compared to those with professional standards.\textsuperscript{443}

3.8 The Real Consent-Law in UK

The earliest record of English law with respect to lack of consent can be traced back to the case of Slater v. Baker and Stapleton in 1767. In this case, physicians removed the bandages from a partially healed leg fracture against patient’s protests. Slater sued doctors for undertaking unwanted treatment. The explicit objections of the patient to the procedure countered any presumption as to the implied consent and doctors were held liable for battery.\textsuperscript{444}

The concept of adequate disclosure for obtaining consent as a standard of medical care has been formulated by the court in Bolam v Frien Hospital Management Committee\textsuperscript{445} in 1957. In this case, the patient sued the hospital and its doctors for negligence in performing electroconvulsive therapy which resulted in an injury. The patient claimed that he was not informed clearly about the possible dangers before taking his consent. Judge McNAIR stated:

\begin{quote}
\ldots(a doctor) is not guilty of negligence, if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art . . . a man is not negligent, if he is acting in accordance with such practice merely because there is a body of opinion who would take a contrary view. At the same time that does not mean that a medical man can obstinately and pigheadedly carry on with some old technique if it has been proved to be contrary to what is really substantially the whole of informed medical opinion . . .”\textsuperscript{446}
\end{quote}

\begin{flushright}
\textsuperscript{443} Studdert et al. supra note 426
\textsuperscript{444} Emma C. Bullock, \textit{Informed Consent And Justified Hard Paternalism}, thesis submitted to the University of Birmingham for the degree of DOCTOR OF PHILOSOPHY, April (2012). \url{http://etheses.bham.ac.uk/3400/2/Bullock_12_PhD.pdf}, Last visited on 29-08-2016 at 22.04
\textsuperscript{446} Bolam supra note 445
\end{flushright}
Similar view was expressed in a Scottish case, *Hunter v. Hanley*\(^{447}\) where, Lord President **CLYDE** said

In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion and one man clearly is not negligent merely because his conclusion differs from that of other professional men, nor because he has displayed less skill or knowledge than others would have shown. The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care.

The case further laid down the requirements to be established by a patient to make the physician liable for negligence.

To establish liability by a doctor where deviation from normal practice is alleged, three facts require to be established. First of all it must be proved that there is a usual and normal practice; secondly it must be proved that the defender has not adopted that practice; and thirdly (and this is of crucial importance) it must be established that the course the doctor adopted is one which no professional man of ordinary skill would have taken if he had been acting with ordinary care.

Bolam test based on *Bolam and Hunter*\(^{448}\) decisions establishes negligence relative to the medical profession. It established disclosure of information as a pre-requisite for obtaining consent. At the same time asserted that ‘the doctor knows better’ and thereby his discretion plays a vital role in deciding ‘what to disclose?’ *Bolam* test is therefore, finding an answer for, ‘what can the reasonable doctor be expected to have disclosed to this patient?’ and never ‘what would the reasonable patient expect to be told?’\(^{449}\)

Later in 1984, through the majority view in *Sidaway v Bethlem Royal Hospital Governors*, the House of Lords affirmed that informed consent is ‘contrary to English law, and the *Bolam* test is appropriate to test the standard of information given to a patient’. Lord **SCARMAN** in his dissenting view expressed that a doctor’s duty to supply information on risks and alternatives derives from the

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\(^{448}\) Bolam v Frien Hospital Management Committee[1957] I W.L.R. 582 and Hunter v. Hanley. 1955 SC 200

patient’s rights. He suggested a different point of view on disclosure of
information to the patient.450 According to Lord Scarman ‘the Bolam
doctrine imposed the duty of care but the standard of care was left for medical
judgment’451. Therefore in such situation, discretion is subject to the test of
reasonability only by one’s own fellowmen, which tends to be potentially
biased. Though Lord SCARMAN’s view was not qualified to be binding, later
years saw much positive critique for this dissenting opinion.

Maynard v. West Midland Regional Health Authority452 was a case of negligent
treatment or diagnosis. In this case, the House of Lords held453 that

“…the true test for establishing negligence in diagnosis or treatment on the part
of a doctor is whether she has been proved to be guilty of such failure as no
doctor of ordinary skill would be guilty of, if acting with ordinary care.”

Lord SCARMAN stated:

A case which is based on an allegation that a fully considered
decision of two consultants in the field of their special skill was
negligent clearly presents certain difficulties of proof. It is not
enough to show that there is a body of competent professional
opinion which considers that theirs was a wrong decision, if
there also exists a body of professional opinion, equally
competent, which supports the decision as reasonable in the
circumstances. It is not enough to show that subsequent events
show that the operation need never have been performed, if at
the time the decision to operate was taken it was reasonable in
the sense that a responsible body of medical opinion would have
accepted it as proper.

English courts have accepted the importance of medical consent. At the same
time, legal actions were limited to situations where absence of any consent is
clearly alleged. The patient’s consent is expected to be ‘real’, in the sense
that, “…the patient [has been] in-formed in broad terms of the nature of the

450 (1985) 1 All ER 643 HL, (1984) 2 WLR 778. id
451 Editorial- Adequately informed consent-Journal of medical ethics, 1985, 11, 115-116,
September 2, 2015 group.bmj.com,Available at: http://jme.bmj.com/content/11/3/115.full.pdf.
Last accessed on 10/11/15 at 3.39
Law in England: Crisis? What Crisis?, Journal of Contemporary Health Law & Policy, 1 J.
accessed 0n 10/11/15 at 3.41 p.m
453 Id
procedure”. In other words, patient must be given “enough time and an environment to enable him ... carefully to consider his... position.454

_Chester v Afshar_455 in 2004 provided a significant development of law in this field. Till that time, the majority of legal debate has revolved around the standard of care and the amount of information patients are entitled receive. Quite differently, here, the issue was of causation456. The patient was suffering from back pain for a long time. As concluded from an MRI scan, there was a disc protrusion into her spinal column and was advised surgery. The neurosurgeon was under a duty to warn the patient that there is a 1-2% risk that even if performed without negligence, the surgery may worsen rather than improve her condition. The operation was performed and it worsened her condition. The plaintiff argued that, if she had been given information about the risk, she would have taken time to decide or look for alternatives. The trial judge held the surgeon not been negligent in performing the operation. But his failure to warn her of the risk was found to be a breach of duty. Being dismissed by the Court of Appeal, defendant approached the House of Lords.457 The surgeon argued that, even if performed at a later stage, the surgery wouldn’t have been successful. Dismissing the appeal Lord HOPE expressed:

To leave the patient who would find the decision difficult without a remedy, as the normal approach to causation would indicate, would render the duty useless in the cases where it may be needed most. This would discriminate against those who cannot honestly say that they would have declined the operation once and for all if they had been warned. I would find that result unacceptable. The function of the law is to enable rights to be vindicated and to provide remedies when duties have been


455 Chester v Afshar [2004] 3 WLR 927 House of Lords http://www.e-lawresources.co.uk/Chester-v-Afshar.php. Last accessed on 10/12/15 at 4.35 p.m


457 Rob Heywood, supra note 456
breached. Unless this is done the duty is a hollow one, stripped of all practical force and devoid of all content. It will have lost its ability to protect the patient and thus to fulfill the only purpose which brought it into existence. On policy grounds therefore I would hold that the test of causation is satisfied in this case. The injury was intimately involved with the duty to warn. The duty was owed by the doctor who performed the surgery that Miss Chester consented to. It was the product of the very risk that she should have been warned about when she gave her consent. So I would hold that it can be regarded as having been caused, in the legal sense, by the breach of that duty.458

The House of Lords accepted the concept that injury is within the scope of the doctor’s duty and omission to provide information can be a cause for injury. This case has further advanced law and established that a doctor has a duty to inform possible complications of any medical procedure.459

Montgomery v. Lanarkshire Health Board 460 is the most recent and epoch making judgment in this area, since it established that informed consent is now part of English law. By this judgment the age old Bolam Test is out of use and the Sidaway judgment is overruled.

Facts of the case

In 1999 Mrs. Montgomery who is a diabetes patient was expecting her first baby. It is a possibility that women suffering from diabetes will have babies that are larger than normal. There can be a particular concentration of weight on the baby’s shoulders known as shoulder dystocia. Mrs. Montgomery’s was regarded as a high risk pregnancy requiring intensive monitoring461. Therefore she has attended the combined obstetric and diabetic clinic at Bellshill Maternity Hospital, under the care of Dr McLellan, throughout her pregnancy. Mrs. Montgomery was told that she was having a larger than usual baby. But she was not told about the chances of difficulties during labor. Dr McLellan

458 Rob Heywood, supra note 456
461 Cusack supra note 460
knowing that this is a high risk case did not want to discuss the potential risks of shoulder dystocia with her patient. According to her, if the condition is mentioned, most women will prefer to have a caesarean section. The labor was induced and after several hours of pain and suffering, it became arrested. Child was pulled out using external devices. During this procedure for 12 minutes, child was deprived of oxygen due to occlusion of the umbilical cord. After birth, the child was diagnosed as suffering from cerebral palsy and brachial plexus affecting all four limbs. Patient sued against the physician claiming that, if informed about the risk, she would have opted for an elective caesarean section which would have saved her son from this injury\textsuperscript{462}.

Two contentions were invoked before the Court of Session. First was about failure to provide adequate information about the risk of shoulder dystocia in vaginal birth. The second was that the doctor was negligent in not electing to do caesarian section in spite of the abnormalities and difficulties in performing a vaginal delivery. The Lower Court, following the \textit{Sidaway} judgment, held that whether a doctor’s omission to warn a patient of inherent risks of proposed treatment constituted a breach of the duty of care was normally to be determined by the application of the test \textit{Bolam} test. Therefore it is subjective, depending on whether the omission was accepted as proper by a responsible body of medical men.

Lord KERR and Lord REED in this decision expressed that, while holding so, the Court of Session did not follow the approach followed in a more recent decision in \textit{Jones v North West Strategic Health Authority}\textsuperscript{463} which had similar facts. In that decision the risk of shoulder dystocia was in itself held to be sufficiently serious for the expectant mother to be entitled to be informed. The Court observed that in England and Wales, although \textit{Sideway’s} case remains binding, lower courts have tacitly ceased to apply the \textit{Bolam} test in relation to disclosure of information. Instead they have effectively adopted the view of Lord

\textsuperscript{462} \textit{Id}
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SCARMAN\textsuperscript{464}. The case of \textit{Pearce v United Bristol Healthcare NHS Trust}\textsuperscript{465} is quoted as an example. This particular case concerned an expectant mother whose baby had gone over term. Physician advised her to wait and have a normal delivery, rather than a caesarean section at an earlier date. The baby happened to die \textit{in utero}. It was held that:

\begin{quote}
In a case where it is being alleged that a plaintiff has been deprived of the opportunity to make a proper decision as to what course he or she should take in relation to treatment, it seems to me to be the law, as indicated in the cases to which I have just referred, 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.\textsuperscript{466}
\end{quote}

Analyzing legal position in some other common law jurisdictions, mainly in Canada and Australia, the Court held that:

\begin{quote}
Since Sidaway... it has become increasingly clear that the paradigm of the doctor-patient relationship implicit in the speeches in that case has ceased to reflect the reality and complexity of the way in which healthcare services are provided, or the way in which the providers and recipients of such services view their relationship. One development which is particularly significant in the present context is that patients are now widely regarded as persons holding rights, as consumers exercising choices..... The treatment.....is now understood to depend not only upon... clinical judgment, but upon bureaucratic decisions as to such matters as resource allocation, cost-containment and hospital administration: decisions which are taken by non-medical professionals...In addition to these developments in society and in medical practice, there have also been developments in the law. Under the stimulus of the Human Rights Act 1998, the courts have become increasingly conscious of the extent to which the common law reflects fundamental values. As Lord Scarman pointed out in Sideway's case, these include the value of self-determination......The correct position, in relation to the risks of injury involved in treatment, can now be seen to be substantially that adopted in Sideway by Lord Scarman, and by Lord Woolf MR in Pearce, subject to the refinement made by the High Court of Australia in Rogers v Whitaker..... An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a
\end{quote}

\textsuperscript{464} supra note 460
\textsuperscript{465} [1999] PIQR P 53
\textsuperscript{466} supra note 460
duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient’s position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.

The significance of Montgomery decision in legal history is that it has established the existence of informed consent doctrine in UK. Law was settled that it is ‘informed consent’ not ‘real consent’ which the doctors need to obtain before medical intervention.

### 3.9 Common Law Jurisdictions

The influence of Canterbury principle is present in other Common law jurisdictions too. In 1980, the Supreme Court of Canada rendered two landmark decisions regarding the duty of a physician to make disclosure to the patient.

In *Hopp v. Lepp*[^467^], the question was whether a patient who suffered permanent damage after the performance of a surgery had given informed consent to the procedure. After suggesting that the patient had a right to decide what, if anything should be done with his body, Laskin C.J. went on to hold that there was a duty of disclosure, that is, the surgeon or physician was bound by a duty to provide information to his or her patient.

In summary, the decided cases appear to indicate that, in obtaining the consent of a patient for the performance upon him of a surgical operation, a surgeon, generally, should answer any specific questions posed by the patient as to the risks involved and should, without being questioned, disclose to him the nature of the proposed operation, its gravity, any material risks and any special or unusual risks attendant upon the performance of the operation. However, having said that, it should be added that the scope of the duty of disclosure and whether or not it has been breached are matters which must be decided in relation to the circumstances of each particular case.

The Supreme Court of Canada again had reason to address the issue of informed consent, among other issues, in the leading case of *Reibl v. Hughes*[^468^]. In this

[^468^]: (1980) 114 DLR (3d) 1
Hopp v. Lepp was considered in the context of the plaintiff’s claim that he had not given informed consent to an endarterectomy procedure that had left him a hemiplegic.\textsuperscript{469}

Broadly speaking, it was the Reibl judgment that introduced the doctrine of informed consent into Canadian law. Building on his reasons in \textit{Hopp v. Lepp}, Laskin C.J., confirmed that the relationship between a doctor and a patient undoubtedly gives rise to a duty of the doctor to disclose material risks associated with a procedure, without having to be questioned by the patient. Thus, the traditional standard of disclosure – that is, what a reasonable physician would disclose – was replaced with the standard of what a reasonable patient would want to know.

While the judgment of Laskin C.J. also restricted the tort of battery to those cases where surgery or treatment was performed or given without any consent or where it went beyond the consent given. The important conclusion was relating to proper test for causation. It was held that the subjective test for causation – that is, what a particular patient would have done if properly informed – should be replaced with a modified objective test that will determine what a reasonable person in the plaintiff’s position would have done if properly informed.\textsuperscript{470}

In saying that the test is based on the decision that a reasonable person in the patient’s position would have made, I should make it clear that the patient’s particular concerns must also be reasonably based; otherwise, there would be more subjectivity than would be warranted under an objective test. Thus, for example, fears which are not related to the material risks which should have been but were not disclosed would not be causative factors. However, economic considerations could reasonably go to causation where, for example, the loss of an eye as a result of non-disclosure of a material risk brings about the loss of a job for which good eyesight is required. In short, although account must be taken of a patient’s particular position, a position which will vary with the patient, it must be objectively assessed in terms of reasonableness.\textsuperscript{471}

\textsuperscript{469} Cusack supra note 459
\textsuperscript{470} Cusack supra note 459
\textsuperscript{471} \textit{Id}
In Canada the decision of Reibl v Hughes settled the law that the doctor has to disclose ‘material’ information and what is ‘material’ is not for the doctor to decide. Prior to this decision, there was some doubt as to whether the doctor had the duty to ensure that patient was understood. However, Laskin C.J. made it quite clear in that case that it was the responsibility of the doctor to make sure that he has understood. Specifically, when the patient had some difficulty with the language spoken by the doctor, he has to take all measures to ensure the proper disclosure of information. The burden is placed on the doctor to show that the patient comprehended the explanation and instructions given.

Providing patients with relevant information is not the only challenging component of the informed consent process. Canadian law clearly imposes some responsibility on physicians to ensure patients understand what they have been told.

To determine if the standard of care owed by the medical practitioner includes an obligation to disclose the information in issue, a court relies on expert evidence as to the general practice of reasonable or prudent doctors regarding disclosure. However, the South Australian Supreme Court has frequently stated that such testimony is not conclusive. If the court finds that the accepted medical practice is below the appropriate legal standard, then a doctor's actions could be held to be a breach of legal duty to inform and hence actionable, even though the physician's conduct conformed to an accepted medical practice. Similarly The High Court of Australia in Rogers v Whitaker imposed an obligation upon practitioners to disclose to patients all material risks inherent in undergoing or forgoing surgery or other interventions. An inherent risk of a procedure is one which ‘cannot be avoided by’ the practitioner’s ‘exercise of reasonable care and skill’. The majority observed that whether, a risk is to be termed as material in the circumstances of the particular case is not the doctor to decide. But, a reasonable person in the patient’s position, if warned of the risk, would be likely to attach significance to it is more important. If warned of

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472 Id
the risk, would the patient likely to attach significance to it is the significant aspect of disclosure.\textsuperscript{477} The Court analyzed Bolam test and rejected that principle. The Court said ‘what the particular plaintiff would have wanted to have been told’ is critical while obtaining consent\textsuperscript{478}.

There is a fundamental difference between, on the one hand, diagnosis and treatment and, on the other hand, the provision of advice or information to the patient . . . because the choice to be made calls for a decision by the patient on information known to the medical practitioner but not to the patient, it would be illogical to hold that the amount of information to be provided by the medical practitioner can be determined from the perspective of the practitioner alone or, for that matter, of the medical profession.\textsuperscript{479}

This tendency is visible in Malaysian Courts as well. In Hong Chuan Lay v Eddie Soo Fook Mun\textsuperscript{480} the court held that it was for the court, and not medical men, to judge the adequacy of information disclosed. In Foo Fio Na v. Dr. Soo Fook Mun\textsuperscript{481}, the Federal Court, the final court of appeal in Malaysia said,

\begin{quote}
We are of the opinion that the Bolam test has no relevance to the duty and standard of care of a medical practitioner in providing advice to a patient on the inherent and material risks of the proposed treatment.” The Federal Court in its conclusions stated that “we are of the view that the Rogers v Whitaker test would be more appropriate and a viable test of this millennium than the Bolam tes\textsuperscript{482}.
\end{quote}

3.10 Medical Consent in India

On medical consent, the Supreme Court of India said:

\begin{quote}
The nature and extent of information to be furnished by the doctor to the patient to secure the consent need not be of the stringent and high-degree mentioned in Canterbury (informed consent) but should be of the extent which is accepted as normal and proper by a body of medical men skilled and experienced in the particular field. It will depend upon the physical
\end{quote}


\textsuperscript{478} Murray Earle, supra note 448

\textsuperscript{479} Id

\textsuperscript{480} Hong Chuan Lay v Dr. Eddie Soo Fook Mun 3 AMR. 2301; 1998

\textsuperscript{481} Foo Fio Na v Dr Soo Fook Mun and Anor. 1, 593 MLJ. 2007

\textsuperscript{482} Rathor et al supra note 420
and mental condition of the patient, the nature of treatment, and the risk and consequences attached to the treatment. 483

Consent given only for a diagnostic procedure cannot be considered as consent for therapeutic treatment. Consent given for a specific treatment procedure will not be valid for conducting some other treatment procedure. The fact that the unauthorized additional surgery is beneficial to the patient, or that it would save considerable time and expense to the patient, or would relieve the patient from pain and suffering in future, are not grounds of defence in an action in tort for negligence or assault and battery484.

In Samira Kohli’s case, the Supreme Court of India states that consent in the context of a doctor–patient relationship is defined as grant of permission by the patient for an act to be carried out by the doctor, such as a diagnostic, surgical or therapeutic procedure. Consent can be implied in some circumstances from the action of the patient. This order gives the principles of consent with regard to medical treatment and therapeutic investigations and not for medical research/clinical trials as follows:-

- A doctor has to seek and secure the consent of the patient before commencing a ‘treatment’. The consent so obtained should be real and valid; the consent should be voluntary; and the consent should be on the basis of adequate information concerning the nature of the treatment procedure, so that she/he knows what she/he is consenting to.
- A balance should be maintained between the need for disclosing necessary and adequate information and at the same time avoid the possibility of the patient being deterred from agreeing to a necessary treatment or offering to undergo an unnecessary treatment.
- Consent given only for a diagnostic procedure cannot be considered as consent for treatment. Consent given for a specific treatment procedure is not valid for some other treatment or procedure.
- There can be a common consent for diagnostic and operative procedures where they are contemplated. There can also be a common consent for a

484 Sameera Kohli Id
particular surgical procedure and an additional or further procedure that may become necessary during the course of surgery.

- The nature and extent of information to be furnished by the doctor to the patient to secure the consent need not be of the stringent and high degree mentioned in *Canterbury* but should be of the extent which is accepted as normal and proper by a body of medical men skilled and experienced in that particular field. It will depend upon the physical and mental condition of the patient, the nature of treatment, and the risk and consequences attached to the treatment.

The Supreme Court of India established that the standard for obtaining consent by the doctor before medical intervention is that of a reasonable doctor followed by House of Lords in *Bolam v Frien Hospital Management Committee* and not the reasonable patient standard which is set up in *Canterbury v. Spence*.

**Facts of the case**

Samira Kohli, an unmarried woman aged 44 years, visited Dr. Prabha Manchanda in the year 1995, complaining of prolonged menstrual bleeding. The respondent examined and advised her to come for a laparoscopy test under general anesthesia, for making an affirmative diagnosis. The patient in this case went to the respondent’s clinic with her mother. The consent form for surgery described the procedure to be undergone as “diagnostic and operative laparoscopy”. Patient was put under general anesthesia and subjected to a laparoscopic examination. When she was still unconscious, a junior doctor, who was assisting Dr. Prabha Manchanda, came out of the operation theatre and took the consent of appellant’s mother for an abdominal hysterectomy (removal of uterus) and bilateral salpingo-oopherectomy (removal of ovaries and fallopian tubes) which was immediately performed. Later, Sameera Kohli lodged a complaint against the physician for unauthorized removal of her reproductive organs.

While analyzing this case law, it is pertinent to note its comparative significance with the judgment delivered by House of Lords in *Sidaway*[^1]. Both were

[^1]: *Sidaway v Bethlem Royal Hospital Governors* (1985) 1 All ER 643 HL
concerning the existence and extent of informed consent and were delivered by the apex courts of the corresponding countries. But their resemblance goes much more deep.

As far as Sidaway is concerned, it has a historical importance. The North American doctrine of informed consent was discussed in England for the first time in this case. Though it was a dissenting opinion, the view expressed by Lord Scarman made a profound impact in English legal and medical academia. In Sidaway case, the plaintiff suffered persistent neck and shoulder pain due to an accident. The defendant surgeon, Mr. Falconer\textsuperscript{486}, performed a spinal disc operation on her which ultimately relieved her discomfort for several years. Later Mrs. Sidaway was admitted to the hospital for evaluation and a myelogram revealed another pressure on a nerve root and was operated. As a result of the surgery, patient’s spinal cord was damaged making her partially paralyzed. She complained that the surgeon has failed to exercise his duty to provide information prior to the operation for obtaining the consent. The House of Lords, by majority, adopted the Bolam test, as the measure of doctor’s duty to disclose information about the potential consequences and risks of proposed medical treatment.

In the dissenting view Lord SCARMAN observed that any kind of medical intervention is against the patient’s autonomy to his body and therefore must be with consent. The patient has the right to take decision about his own body:

If, therefore, the failure to warn a patient of the risks inherent in the operation which is recommended does constitute a failure to respect the patient’s right to make his own decision, I can see no reason in principle why, if the risk materialises and injury or damage is caused, the law should not recognise and enforce a right in the patient to compensation by way of damages.\textsuperscript{487}

Lord SCARMAN brought attention to another important aspect involved in the actual process of consent. The reasons which the doctor considered important for decision making need not be the same as that of the patient. Patients may

\textsuperscript{486} Surgeons are addressed as Mr. in England, whereas all other M.D.s are called Dr. See Frances H. Miller, \textit{Informed Consent For The Man On The Clapham Omnibus: An English Cure For “The American Disease”?} Western New England Law Review, 9 W. New Eng. L. Rev. 169 (1987).

\textsuperscript{487} supra note 460
have an entirely different set of grounds which he considers significant for his decision. They need not necessarily be ‘medical’. Therefore it is indispensable that the patient gets information on all material facts affecting his decision making. He concluded that information is material if a patient considers it to be important. The Doctor has a duty to provide information about those material risks which a ‘prudent patient’ in the situation of the patient would have considered significant. Any omission on the part of the doctor to provide such information can be considered as negligence.

However, the majority viewed that the test of liability in respect of a doctor's duty to warn his patient of risks is “in accordance with the practice accepted at the time as proper by a responsible body of medical opinion.” The House of Lords upheld the decision of the Court of Appeal that the doctrine of informed consent based on full disclosure of all the facts to the patient, is not the appropriate test of liability for negligence, under English law.

Lord BRIDGE stated:

I recognize the logical force of the Canterbury doctrine, proceeding from the premise that the patient's right to make his own decision must at all costs be safeguarded against the kind of medical paternalism which assumes that 'doctor knows best'. But, with all respect, I regard the doctrine as quite impractical in application….

RAVEENDRAN, J. in Samira Kohli, makes a thorough analysis of the North American doctrine of Informed Consent. The Canterbury judgment is quoted at length:

True consent to what happens to one's self is the informed exercise of a choice… To the physician, whose training enables a self- satisfying evaluation, the answer may seem clear, but it is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie.

However the Court finds that this principle was not accepted in England as Bolam Test was always the authority. An analysis of both the opinions expressed in Sidaway judgment is made to conclude that the high standards of

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488 Samira Kohli v. Prabha Manchanda and Ors. I (2008) CPJ 56 (SC
489 Id
CHAPTER III - CONSENT AND INFORMED CONSENT: LEGAL SCENARIO

Canterbury were not found practical even in England. Referring to the judgments delivered by the Indian Supreme Court in Achutrao Haribhau Khodwa v. State of Maharashtra\textsuperscript{491} and Vinita Ashok v. Lakshmi Hospital\textsuperscript{492}, the Court reaches to similar findings about India.

At the same time, the Hon’ble Justice makes due note of the radical expression in Vinita Ashok’s case, which goes beyond the standard set by Bolam:

\ldots doctor will be liable for negligence in respect of diagnosis and treatment in spite of a body of professional opinion approving his conduct where it has not been established to the court's satisfaction that such opinion relied on is reasonable or responsible. If it can be demonstrated that the professional opinion is not capable of withstanding the logical analysis, the court would be entitled to hold that the body of opinion is not reasonable or responsible.

The judgment further widens its dimension to the socio-political aspects of health care in India

\ldots majority of citizens requiring medical care and treatment fall below the poverty line. Most of them are illiterate or semi-literate. They cannot comprehend medical terms, concepts, and treatment procedures. They cannot understand the functions of various organs or the effect of removal of such organs. They do not have access to effective but costly diagnostic procedures. Poor patients lying in the corridors of hospitals after admission for want of beds or patients waiting for days on the roadside for an admission or a mere examination, is a common sight. For them, any treatment with reference to rough and ready diagnosis based on their outward symptoms and doctor's experience or intuition is acceptable and welcome so long as it is free or cheap; and whatever the doctor decides as being in their interest, is usually unquestioningly accepted. They are a passive, ignorant and uninvolved in treatment procedures. The poor and needy face a hostile medical environment - inadequacy in the number of hospitals and beds, non-availability of adequate treatment facilities, utter lack of qualitative treatment, corruption, callousness and apathy…..

The Court finds doctors in public sector as overworked, understaffed, with little or no facilities and limited choice of medicines and treatment procedures.

Some stark observations about the Private sector,

\ldots There is a general perception among the middle class public that these private hospitals and doctors prescribe avoidable costly diagnostic procedures and medicines, and subject them to unwanted surgical procedures, for financial gain. The public feel that many doctors who

\textsuperscript{491} 1996 (2) SCC 634, \\
\textsuperscript{492} 2001 (8) SCC 731
have spent a crore or more for becoming a specialist, or nursing homes which have invested several crores on diagnostic and infrastructure facilities, would necessarily operate with a purely commercial and not service motive; that such doctors and hospitals would advise extensive costly treatment procedures and surgeries, where conservative or simple treatment may meet the need; and that what used to be a noble service oriented profession is slowly but steadily converting into a purely business. Unfortunately, the noble tribe is dwindling. Every Doctor wants to be a specialist. The proliferation of specialists and super specialists, have exhausted many a patient both financially and physically, by having to move from doctor to doctor, in search of the appropriate specialist.

The adverse impact of legal measures against private players in health sector are identified.

.... More and more private doctors and hospitals have, of necessity, started playing it safe, by subjecting or requiring the patients to undergo various costly diagnostic procedures and tests to avoid any allegations of negligence... more and more doctors particularly surgeons in private practice are forced to cover themselves by taking out insurance, the cost of which is also ultimately passed on to the patient, by way of a higher fee...

The Judgment, takes due care in establishing a clear standard on medical consent in India. And the attempts to balance the interests of either side are remarkable. The statement, “adequate information to be furnished by the doctor......to enable the patient to make a balanced judgment”, solely qualifies the celebrated standard of “informed consent” expressed by Canterbury in 1972. According to Canterbury, “To enable the patient to chart his course understandably, some familiarity with the therapeutic alternatives and their hazards becomes essential...... It is a duty to warn of the dangers lurking in the proposed treatment, and that is surely a facet of due care.”

But the Supreme Court at this point withdraws from making a bold change in the law and concludes in this way:

The nature and extent of information to be furnished by the doctor to the patient to secure the consent need not be of the stringent and high degree mentioned in Canterbury but should be of the extent which is accepted as normal and proper by a body of medical men skilled and experienced in the particular field.
It is affirmed that, even though it may appear to be not in favor of recent trends, we must follow Bolam test. The Court makes a mention that the principle is being challenged in its birth place itself. “Lord Scarman's minority view in Sidaway favoring Canterbury… may ultimately become the law in England... Inevitably, a day may come when we may have to move towards Canterbury. But not for the present.”

When is that time which will be apt for us to move towards Canterbury? “… if medical practitioners and private hospitals become more and more commercialized, and if there is a corresponding increase in the awareness of patient's rights among the public...”

The standard set by the Supreme Court is followed in later decisions by various courts. In Ram Gopal Varshney’s case, the National Commission allowed the complaint for the reason that there was no informed consent obtained from the patient and though there was no deficiency in service on the part of the treating doctor insofar as the treatment administered to the patient is concerned. In Dhanwanti Kaur’s case surgery for removal of stones in gall bladder was performed upon the patient by adopting laparoscopic procedure and the doctor without obtaining the consent of the complainant’s husband opted for open cholecystectomy. The National Commission held that there was no informed consent from the complainant or her husband for conducting open cholecystectomy and the opposite party failed to exercise requisite care and attention during postoperative stage. In Baidya Nath Chakraborty (Dr) v. Chandi Bhattacharjee, it was held that consent of the patient has to be on the basis of ‘adequate information’ concerning the nature of the treatment procedure, so that he knows what he is consenting to. ‘Adequate information’ should enable the patient to make a balanced judgment as to whether he should submit himself to the particular treatment or not, and it would include disclosure of information regarding alternatives, if any available. In G. Rajendra vs. City Hospital and others, the National commission held that, consent taken prior, even to the

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493 Vinita Ashok Id
494 Ram Gopal Varshney v. Lasor Sigt India Pvt ltd and another.(2009)CPJ 23(NC)
495 Dhanwanti Kaur v. S.K.Jhujhunwala(Sr) and another 2010(6) ALD 19(NC)
496 II(2014)CPJ 601 (NC)
497 III(2014) CPJ 598 (NC)
decision on choice of procedure can, by no stretch of imagination be ‘informed consent’.

In *Convenient Hospitals v. Sankar Lai* 498, it was held by the National Commission that consent obtained was defective for the reason that the alternatives to angioplasty were not explained to the patient. In *Smt. Saroj Chandhoke v. Sir Ganga Ram Hospital* 499, after a Hysterectomy, the complainant lost her ovaries and left kidney. She was required to undergo other operations for control of fecal discharge from vagina and prolonged stay in the hospital for months. It was alleged, there was no emergent requirement for trying to operate via vaginal route and no consent was obtained for removal of ovaries in advance planned surgery. The patient was prepared for Hysterectomy and had given written consent for it. No consent was obtained or no information was given to the patient that her ovaries would be removed. It was held that:

…it cannot be said that because a surgeon is expert in the field he/she can carry out the surgery of his choice. If he does so, he/she does it at his risk in case of mishap…. No doubt, in case of emergency there can be deviation in mode of surgery, but not in a planned surgery where express consent for a particular mode is taken from the patient, particularly, when there is no emergency…. before performing surgery, properly informed written consent is must. No doubt, while operating, to control adverse situation or to save the life of the patient or for benefit of the patient, other procedure could be followed or other part of the body could be operated… it is to be seen that superiority of the doctor is not abused in any manner”

In *K. A. Bhandula & Another v. Indraprastha Apollo Hospital & Others* 500, the National Commission summarised principles relating to consent as follows:

(i) A doctor has to seek and secure the consent of the patient before commencing a treatment (the term treatment includes surgery also). The consent so obtained should be real and valid, which means that the patient should have the capacity and competence to consent; his consent should be voluntary; and his consent

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498 [I(2015)CPJ 134 (NC)]
499 [III (2007) CPJ 189 NC]
500 [III (2009) CPJ 164 (NC)]
should be on the basis of adequate information concerning the nature of the treatment procedure, so that he knows what he is consenting to.

(ii) The adequate information to be furnished by the doctor (or a member of his team) who treats the patient, should enable the patient to make a balanced judgment as to whether he should submit himself to the particular treatment or not. This means that the doctor should disclose (a) nature and procedure of the treatment and its purpose, benefits and effect; (b) alternatives if any available; (c) an outline of the substantial risks; and (d) adverse consequences of refusing treatment. But there is no need to explain remote or theoretical risks involved, which may frighten or confuse a patient and result in refusal of consent for the necessary treatment. Similarly, there is no need to explain the remote or theoretical risks of refusal to take treatment which may persuade a patient to undergo a fanciful or unnecessary treatment. A balance should be achieved between the need for disclosing necessary and adequate information and at the same time avoid the possibility of the patient being deterred from agreeing to a necessary treatment or offering to undergo an unnecessary treatment.

3.11 DOCTOR–PATIENT RELATIONSHIP: CURRENT SCENARIO

As per the available data, there is an increased use of technology in diagnostics and treatment of diseases in India, coupled with rising knowledge and expectations of the population regarding therapeutic measures, causing cost of health care becoming exorbitant. This increase has led to inequity in access to healthcare services. Another alarming fact is that, the share of centre in total public expenditure on health is declining steadily over the years. In India public spending on health, as a percentage of GDP, is one of the lowest among South-East Asian countries and the lowest among Brazil, Russia, India and China (BRIC nations). In *Vincent Panikulangara vs. Union of India*, the Supreme Court of India observed: “Maintenance and improvement of public health have

503 AIR 1987 SC 990
to rank high as these are indispensable to the very physical existence of the community and on the betterment of these depends the building of the society of which the Constitution makers envisaged.”

Doctors and patients, even if they come from the same social and cultural background, view ill health in different ways. In India they are in fact from two different worlds. Specialization and super-specialization is producing a generation of doctors whose focus is miniscule. The objective approach towards general medicine and treatment is disappearing. The healthcare system in India is one of the most privatized in the world. The latest in technological medicine is available to those who can afford to pay a higher price; but the vast majority, has little or no access to healthcare.

In a study conducted on doctor patient relationship, it was reported that socio cultural factors influence concordance of patients with doctors. Higher economic status is related to better concordance. Urban patients enjoyed better compatibility than their rural counterparts. People who did not share a common mother tongue with the doctors were less benefitted by interaction. It was clearly observed that better trust in physician was related to better patient enablement. And the major challenges to the doctor patient concordance is decreasing generalization, cultural & educational barriers and increasing commercialization of medical practice. The doctor patient relationship is the keystone of healthcare and essentials of a good doctor patient relationship are clear communication, mutual respect, confidentiality, professional honesty and trust. Doctor and the patient contribute to it. But there is a higher responsibility on the part of the doctor to ensure its presence, being professional whose services are sought and paid for.

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505 Id

506 David Berger, Corruption Ruins The Doctor-Patient Relationship In India,. BMJ 348:G3169 Doi:10.1136/Bmj.g3169 (8 May 2014). (Last visited on 15-10-2015 at 7.25 a.m).ww.bmj.com/content/348/bmj.g3169. (Personal View)

507 Banerjee, & Sanyal supra note 504

508 Dhingra & Anand supra note 417
In 2008, the Supreme Court observed that the ‘noble tribe’ is dwindling. Since then it has taken a faster pace and the healthcare sector is dangerously commercialized today.

The opinion expressed by the Punjab & Haryana High Court in Daljit Singh’s case reflects the state of affairs more clearly:

Medical profession is one of the oldest professions of the world and is the most humanitarian one. There can be no better service than to serve the suffering, wounded and the sick….Unfortunately, now a days with the upcoming of corporate culture, medical profession which was highly respected is indicating decline of standards ….

The ordinary citizen approaching judiciary in medical negligence cases is ill-informed, less-empowered and therefore ill-equipped to fight the legal battle. The very delicate-physical, mental and financial-situation in which he is in, prevents him from understanding the negligence, collecting evidences and pursuing it for a long time. On the other side, there is a well-equipped and powerful machinery who can afford to create and sustain its defenses.

3.12 Patients Autonomy: Human Rights Perspective

Patient’s rights emanate fundamentally from Human Rights. The underlying concept of Human Rights is that people have inherent rights because they are human beings. WHO’s definition of health includes physical, mental, social, environmental and spiritual health.

The Indian Constitution incorporates provisions guaranteeing everyone’s right to the highest attainable standard of physical and mental health. Article 21 of the Constitution guarantees protection of life and personal liberty to every citizen. The Supreme Court in Bandhua Mukti Morcha v. Union of India has made it candid that the right to live with human dignity, enshrined in Article 21, is derived from the directive principles of state policy and therefore includes

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509 Singh Daljit Singh Gujral v. Jagjit Arora (2014) 41 SCD 269
511 Bandhua Mukti Morcha v. Union of India. AIR 1984 SC 802
protection to health. Other civil rights, consumer rights, codes of ethics of medical and nursing profession are also protecting patient’s rights in India. Basic optimal health care is the right of every Indian citizen and it is the responsibility of the state to provide it. Any threat to health care must be considered as denial of the Right to Life.

The right to self-determination is one of the most important principles of international law. Many international human rights documents include rights of self-determination in their lists of basic human rights. This right provides for individual autonomy, human dignity, self-consciousness and the right to choose. Although right to privacy has not been expressly mentioned in the Indian Constitution, it is a part of Article 21 which talks about Right to life and personal liberty. The privacy is that “area of a man’s life which in any given circumstances a reasonable man with an understanding of the legitimate needs of the community would think it wrong to invade.” This right to privacy has been widely acclaimed and recognized in international documents, such as Article 17 of the International Covenant the Civil and Political Rights, 1966 and Article 12 of the Universal Declaration of the Universal Rights, 1948. This right empowers a patient to refuse treatment. A patient who is competent enough has a right to make his own medical decision according to his wish. The general presumption in medical care cases is that a competent individual has a freedom

513 Maya Abdullah, The Right To Self-Determination In International Law, Master thesis submitted to Department of Law, School of Economics and Commercial Law, University of Goteborg. [https://gupea.ub.gu.se/bitstream/2077/1888/1/gupea_2077_1888_1.pdf]. Last visited on 6-10-2016 at 10.27
516 India is a signatory to the Universal Declaration of Human Rights, 1948 and the International Covenant on Civil and Political Rights, 1966. Article 12 of UDHR and Article 17 of ICCPR states:
No one shall be subject to arbitrary or unlawful interference with his privacy, family, human or correspondence, or to lawful attacks on his honor and reputation. Everyone has the right to the protection of the law against such interference or attacks.
to make his choice and control his destiny under the right to privacy, even when such decision may go against his own interest.\textsuperscript{517}

### 3.13 Patient in the Information Era

India is a country of diversities. Same is true with respect to healthcare sector also. While majority of patients are illiterate and passive participants in the medical practices, the other group, is also very much present. The new age patient is arriving clinic armed with information available on the web. Usage of internet rapidly increased. Not just the basic information, the ‘e-patient’ has easy access to latest developments, various different treatment models available for the conditions and can make an intelligent choice.\textsuperscript{518} The bygone era, due to lack of information, was the period of “Doctor Knows the best”. However, in the information age, patients are empowered with information. They are no longer for blind trust and demand information to qualify their trust.\textsuperscript{519}

The tremendous advances in medical technology, the high costs of health care, the scarcity of resources, the rise in public expectations and the shift in values require intensive consideration of the future of the health system.\textsuperscript{520} Novel situations demand certain and modified legal principles to ensure justice. It is necessary to understand the principles that call for decisions involving health care. It is the responsibility of the law makers to remove the contradictions and uncertainties in the respective arena.

\textsuperscript{517} supra note 514. See also, People’s Union Of Civil Liberties v. Union Of India And Anr. (1997) 1 SCC 301, “It is almost an accepted proposition of law that the rules of customary international law which are not contrary to the municipal law shall be deemed to be incorporated in the domestic law.”


\textsuperscript{519} Divekar & Sukhadeve supra note 518

\textsuperscript{520} Amnon Carmi,(ed), Informed Consent, UNESCO Chair in Bio Ethics, The International Center For Health, Law And Ethics, Faculty Of Law, University Of Haifa, Israel (2003). \url{http://unesdoc.unesco.org/images/0014/001487/148713e.pdf}. Last visited on 30-08-2016 at 15.44.
3.14 Conclusion

In Samira Kohli’s case, the honorable Supreme Court has expressed that if medical practice becomes more commercialized, and if there is a corresponding increase in the awareness among the public, we may have to move towards Canterbury Principle of Informed consent. An analysis of the current state of health sector, more importantly of the doctor-patient relationship and the awareness level of patients indicates the presence of both these elements and therefore, it is high time, we moved towards the strict standards of informed consent.

By the Montgomery decision, Bolam Test is out of use and the Sidaway judgment is overruled. It is established that informed consent is now part of English law. Courts in Australia, Malaysia, New Zealand, Ireland, and Canada, following common law system have legal system requiring informed consent from the patient’s point of view.

Rapid commercialization of medical practice has made patients in India more vulnerable. Hence, there is a dare need of legal protection from paternalistic and arbitrary medical intervention. There is an increasing awareness among the public about their rights and basic information on medicine and treatment as well, due to the internet revolution.

One of the arguments leveled against strict standards of Canterbury principle is that, it will bring in higher cost-structure of American medical care. And patients in India cannot afford it. However as Supreme Court observed maintenance and improvement of public health have to rank high in the list of priority for any government. It is a Constitutional obligation. Therefore strict regulation at all levels is an urgent priority. Along with this there has to be an increase in public funding to make Indian healthcare affordable and reliable as well.

A person's basic rights are established on recognition of his human status, the inviolability of his life and the fact that he was born, and will always be, free. Respect for the values and wishes of the individual is a duty which becomes even stronger if the individual becomes vulnerable. Since the autonomy and responsibility of every person, including those who need health care, are
accepted as important values, reaching or participating in decisions concerning one's own body or health must be recognized as a right. For medical practice to be effective there should be concordance between the doctor and patient. This being a fiduciary relationship has its foundation well laid in mutual trust and candor. The doctor is no longer ‘God’ and patient the blind devotee. Social dimensions are changing and corresponding changes are required in legal system as well.

In India, there is no specific legislation dealing with standard or adequacy of information provided to a patient before any kind of medical intervention. The formalities which will validate consent and excuse the doctor from liability are scattered in various legislations, such as IPC, Cr.P.C, Medical Termination of Pregnancy Act, Indian Contract Act etc. Ostensively, they are dealing with some special situations specifically dealt under such statutes. Besides, these provisions are technical as they focus on capacity of the patient and other formalities rather than the adequacy of information which will facilitate a decision making at the patient’s end. In Indian legal context, requirement of consent is clear but what constitutes an ideal consent is still elusive and subject to interpretations.

Whether the time has come for moving to Canterbury principle continues to be a subject of academic debate. But the critical question is, ‘what is the standard which we want to keep as bench mark for transparency on the part of doctor?’ In a country where individual autonomy is well-recognized by the Constitution, this ambiguity leads to violation of fundamental rights. This position needs to be rectified by adequate and timely law making.

We need to get ahead of the 20th century principles of English law. Nevertheless not to try importing the North American doctrine as such is also advisable. The socio-political situations in which doctor work and patient live in India has to be in background while arriving at the standard. The rampant commercialization of health sector, disparage in public health services, abase in the value of medical education and the dangerous level of information gap are some of the important areas which needs consideration. A comprehensive legislation

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521 supra note 230
clarifying the need, standard and adequacy of valid medical consent is the exigent need of the country.