CASE NO.:
Appeal (civil) 1949 of 2004

PETITIONER:
Samira Kohli

RESPONDENT:
Dr. Prabha Manchanda & Anr.

DATE OF JUDGMENT: 16/01/2008

BENCH:
B. N. Agarwal, P. P. Naolekar & R. V. Raveendran

JUDGMENT:
J U D G M E N T

RAVEENDRAN, J.

This appeal is filed against the order dated 19.11.2003 passed by the National Consumer Disputes Redressal Commission (for short 'Commission') rejecting the appellant\022s complaint (O.P. No.12/1996) under Section 21 of the Consumer Protection Act, 1986 (\021Act\022 for short).

Undisputed facts

2. On 9.5.1995, the appellant, an unmarried woman aged 44 years, visited the clinic of the first respondent (for short \021the respondent\022) complaining of prolonged menstrual bleeding for nine days. The respondent examined and advised her to undergo an ultrasound test on the same day. After examining the report, the respondent had a discussion with appellant and advised her to come on the next day (10.5.1995) for a laparoscopy test under general anesthesia, for making an affirmative diagnosis.

3. Accordingly, on 10.5.1995, the appellant went to the respondent's clinic with her mother. On admission, the appellant's signatures were taken on (i) admission and discharge card; (ii) consent form for hospital admission and medical treatment; and (iii) consent form for surgery. The Admission Card showed that admission was \023for diagnostic and operative laparoscopy on 10.5.1995". The consent form for surgery filled by Dr. Lata Rangan (respondent's assistant) described the procedure to be undergone by the appellant as "diagnostic and operative laparoscopy. Laparotomy may be needed". Thereafter, appellant was put under general anesthesia and subjected to a laparoscopic examination. When the appellant was still unconscious, Dr. Lata Rengen, who was assisting the respondent, came out of the Operation Theatre and took the consent of appellant\022s mother, who was waiting outside, for performing hysterectomy under general anesthesia. Thereafter, the Respondent performed a abdominal hystecrectomy (removal of uterus) and bilateral salpingo-oopherectomy (removal of ovaries and fallopian tubes). The appellant left the respondent\022s clinic on 15.5.1995 without settling the bill.

4. On 23.5.1995, the respondent lodged a complaint with the Police alleging that on 15.5.1995, the Appellant's friend (Commander Zutshi) had abused and threatened her (respondent) and that against medical advice, he got the appellant discharged without clearing the bill. The appellant also lodged a complaint against the respondent on 31.5.1995, alleging negligence and unauthorized removal of her reproductive organs. The first respondent issued a legal notice dated 5.6.1995 demanding Rs.39,325/- for professional services. The appellant sent a reply dated

12.7.1995. There was a rejoinder dated 18.7.1995 from the respondent and a further reply dated 11.9.1995 from the appellant. On 19.1.1996 the appellant filed a complaint before the Commission claiming a compensation of Rs.25 lakhs from the Respondent. The appellant alleged that respondent was negligent in treating her; that the radical surgery by which her uterus, ovaries and fallopian tubes were removed without her consent, when she was under general anesthesia for a Laparascopic test, was unlawful, unauthorized and unwarranted; that on account of the removal of her reproductive organs, she had suffered premature menopause necessitating a prolonged medical treatment and a Harmone Replacement Therapy (HRT) course, apart from making her vulnerable to health problems by way of side effects. The compensation claimed was for the loss of reproductive organs and consequential loss of opportunity to become a mother, for diminished matrimonial prospects, for physical injury resulting in the loss of vital body organs and irreversible permanent damage, for pain, suffering emotional stress and trauma, and for decline in the health and increasing vulnerability to health hazards.

5. During the pendency of the complaint, at the instance of the respondent, her insurer - New India Assurance Co. Ltd, was impleaded as the second respondent. Parties led evidence - both oral and documentary, Appellant examined an expert witness (Dr. Puneet Bedi, Obstetrician & Gynaecologist), her mother (Sumi Kohli) and herself. The respondent examined herself, an expert witness (Dr. Sudha Salhan, Professor of Obstetrics & Gynaecology and President of Association of Obstetricians and Gynaecologists of Delhi), Dr. Latha Rangan (Doctor who assisted the Respondent) and Dr. Shiela Mehra (Anaesthetist for the surgery). The medical records and notices exchanged were produced as evidence. After hearing arguments, the Commission dismissed the complaint by order dated 19.11.2003. The Commission held : (a) the appellant voluntarily visited the respondent\022s clinic for treatment and consented for diagnostic procedures and operative surgery; (ii) the hysterectomy and other surgical procedures were done with adequate care and caution; and (iii) the surgical removal of uterus, ovaries etc. was necessitated as the appellant was found to be suffering from endometriosis (Grade IV), and if they had not been removed, there was likelihood of the lesion extending to the intestines and bladder and damaging them. Feeling aggrieved, the appellant has filed this appeal.

The appellant\022s version :

6. The appellant consulted respondent on 9.5.1995. Respondent wanted an ultra-sound test to be done on the same day. In the evening, after seeing the ultrasound report, the respondent informed her that she was suffering from fibroids and that to make a firm diagnosis, she had to undergo a laparoscopic test the next day. The respondent informed her that the test was a minor procedure involving a small puncture for examination under general anesthesia. The respondent informed her that the costs of laparoscopic test, hospitalization, and anesthetists charges would be around Rs.8000 to 9,000. Respondent spent hardly 4 to 5 minutes with her and there was no discussion about the nature of treatment. Respondent merely told her that she will discuss the line of treatment, after the laparoscopic test. On 10.5.1995, she went to the clinic only for a diagnostic laparoscopy. Her signature was taken on some blank printed forms without giving her an opportunity to read the contents. As only a diagnostic procedure by way of a laparoscopic test was to be conducted, there was no discussion, even on 10.5.1995, with regard to any proposed treatment. As she was intending to marry within a month and start a family, she would have refused consent for removal of her reproductive organs and would have opted for conservative treatment, had she been informed about any proposed surgery for removal of her reproductive organs.

7. When the appellant was under general anaesthesia, respondent rushed out of the operation theatre and told appellant's mother that she had started bleeding profusely and gave an impression that the only way to save her life was by performing an extensive surgery. Appellant's aged mother was made to believe that there was a life threatening situation, and her signature was taken to some paper. Respondent did not choose to wait till appellant regained consciousness, to discuss about the findings of the laparoscopic test and take her consent for treatment. The appellant was kept in the dark about the radical surgery performed on her. She came to know about it, only on 14.5.1995 when respondent\022s son casually informed her about the removal of her reproductive organs. When she asked the respondent as to why there should be profuse bleeding during a Laparoscopic test (as informed to appellant's mother) and why her reproductive organs were removed in such haste without informing her, without her consent, and without affording her an opportunity to consider other options or seek other opinion, the respondent answered rudely that due to her age, conception was not possible, and therefore, the removal of her reproductive organs did not make any difference.

8. As she was admitted only for a diagnostic procedure, namely a laparoscopy test, and as she had given consent only for a laparoscopy test and as her mother\022s consent for conducting hysterectomy had been obtained by misrepresentation, there was no valid consent for the radical surgery. The respondent also tried to cover up her unwarranted/negligent act by falsely alleging that the appellant was suffering from endometriosis. The respondent was guilty of two distinct acts of negligence: the first was the failure to take her consent, much less an informed consent, for the radical surgery involving removal of reproductive organs; and the second was the failure to exhaust conservative treatment before resorting to radical surgery, particularly when such drastic irreversible surgical procedure was not warranted in her case. The respondent did not inform the appellant, of the possible risks, side effects and complications associated with such surgery, before undertaking the surgical procedure. Such surgery without her consent was also in violation of medical Rules and ethics. Removal of her reproductive organs also resulted in a severe physical impairment, and necessitated prolonged further treatment. The respondent was also not qualified to claim to be a specialist in Obstetrics and Gynaecology and therefore could not have performed the surgery which only a qualified Gynaecologist could perform.

The respondent\022s version

9. The appellant had an emergency consultation with the respondent on 9.5.1995, complaining that she had heavy vaginal bleeding from 30.4.1995, that her periods were irregular, and that she was suffering from excessive, irregular and painful menstruation (menorrhagia and dysmenorrhea) for a few months. On a clinical examination, the respondent found a huge mass in the pelvic region and tenderness in the whole area. In view of the severe condition, Respondent advised an ultrasound examination on the same evening. Such examination showed fibroids in the uterus, a large chocolate cyst (also known as endometrical cyst) on the right side and small cysts on the left side. On the basis of clinical and ultra sound examination, she made a provisional diagnosis of endometriosis and informed the appellant about the nature of the ailment, the anticipated extent of severity, and the modality of treatment. She further informed the appellant that a laparoscopic examination was needed to confirm the diagnosis; that if on such examination, she found that the condition was manageable with conservative surgery, she would only remove the chocolate cyst and fulgurate the endometric areas and follow it by medical therapy; and that if the lesion was extensive, then considering her age and likelihood of destruction of the function of the tubes, she will perform hysterectomy. She also explained the surgical

procedure involved, and answered appellant's queries. The appellant stated that she was in acute discomfort and wanted a permanent cure and, therefore whatever was considered necessary, including a hysterectomy may be performed. When appellant\022s mother called on her on the same evening, the respondent explained to her also about the nature of disease and the proposed treatment, and appellant's mother stated that she may do whatever was best for her daughter. According to the accepted medical practice, if endometriosis is widespread in the pelvis causing adhesions, and if the woman is over 40 years of age, the best and safest form of cure was to remove the uterus and the ovaries. As there is a decline in fecundity for most women in the fourth decade and a further decline in women in their forties, hysterectomy is always considered as a reasonable and favoured option. Further, endometriosis itself affected fertility adversely. All these were made known to the appellant before she authorised the removal of uterus and ovaries, if found necessary on laparoscopic examination.

10. On 10.5.1995, the appellant\022s consent was formally recorded in the consent form by Dr. Lata Rangan - respondent's assistant. Dr. Lata Rangan informed the appellant about the consequences of such consent and explained the procedure that was proposed. The appellant signed the consent forms only after she read the duly filled up forms and understood their contents. All the requisite tests to be conducted mandatorily before the surgery were performed including Blood Grouping, HIV, Hemoglobin, PCV, BT, CT and ECG. The laparoscopic examination of the uterus surface confirmed the provisional diagnosis of endometriosis. The right ovary was enlarged and showed a chocolate cyst stuck to the bowel. Right tube was also involved in the lesion. The left ovary and tube were also stuck to the bowel near the cervix. A few small cysts were seen on the left ovary. The pelvic organs were thick and difficult to mobilize. Having regard to the extent of the lesion and the condition of appellant's uterus and ovaries, she decided that conservative surgery would not be sufficient and the appellant\022s problem required removal of uterus and ovaries. The respondent sent her assistant, Dr. Lata Rangan to explain to appellant\022s mother that the lesion would not respond to conservative surgery and a hysterectomy had to be performed and took her consent. The surgery was extremely difficult due to adhesions and vascularity of surface. A \021sub-total hysterectomy\022 was done followed by the removal of \021rest of the stump of cervix\022. As the right ovary was completely stuck down to bowel, pouch of douglas, post surface and tube, it had to be removed piecemeal. When appellant regained consciousness, she was informed about the surgery. The appellant felt assured that heavy bleeding and pain would not recur. There was no protest either from the appellant or her mother, in regard to the removal of the ovaries and uterus.

11. However, on 15.5.1995, Commander Zutshi to whom appellant was said to have been engaged, created a scene and got her discharged. At the time of discharge, the summary of procedure and prescription of medicines were given to her. As the bill was not paid, the respondent filed Suit No.469/1995 for recovery of the bill amount and the said suit was decreed in due course.

12. Respondent performed the proper surgical procedure in pursuance of the consent given by the appellant and there was no negligence, illegality, impropriety or professional misconduct. There was real and informed consent by the appellant for the removal of her reproductive organs. The surgery (removal of uterus and ovaries), not only cured the appellant of her disease but also saved her intestines, bladder and ureter from possible damage. But for the surgical removal, there was likelihood of the intestines being damaged due to extension of lesion thereby causing bleeding, fibrosis and narrowing of the gut; there was also likelihood of the lesion going to the surface of the bladder penetrating the wall and causing haematuria and the ureter being damaged due to fibrosis and leading to damage of the kidney, with a reasonable real chance of

developing cancer. As the complainant was already on the wrong side of 40 years which is a peri-menopausal age and as the appellant had menorrhagia which prevented her from ovulating regularly and giving her regular cycle necessary for pregnancy and as endometriosis prevented fertilization and also produced reaction in the pelvis which increased the lymphocytes and macrophages which destroyed the ova and sperm, there was no chance of appellant conceiving, even if the surgery had not been performed. The removal of her uterus and ovaries was proper and necessary and there was no negligence on the part of the respondent in performing the surgery. A Doctor who has acted in accordance with a practice accepted as proper by medical fraternity cannot be said to have acted negligently. In the realm of diagnosis and treatment there is ample scope for genuine differences of opinion and no Doctor can be said to have acted negligently merely because his or her opinion differs from that of other Doctors or because he or she has displayed lesser skill or knowledge when compared to others. There was thus no negligence on her part.

Questions for consideration :

13. On the contentions raised, the following questions arise for our consideration :
(i) Whether informed consent of a patient is necessary for surgical procedure involving removal of reproductive organs? If so what is the nature of such consent ?

(ii) When a patient consults a medical practitioner, whether consent given for diagnostic surgery, can be construed as consent for performing additional or further surgical procedure -- either as conservative treatment or as radical treatment -- without the specific consent for such additional or further surgery.

(iii) Whether there was consent by the appellant, for the abdominal hysterectomy and Bilateral Salpingo-oopherectomy (for short AH-BSO) performed by the respondent?

(iv) Whether the respondent had falsely invented a case that appellant was suffering from endometriosis to explain the unauthorized and unwarranted removal of uterus and ovaries, and whether such radical surgery was either to cover-up negligence in conducting diagnostic laparoscopy or to claim a higher fee ?

(v) Even if appellant was suffering from endometriosis, the respondent ought to have resorted to conservative treatment/surgery instead of performing radical surgery ?

(vi) Whether the Respondent is guilty of the tortious act of negligence/battery amounting to deficiency in service, and consequently liable to pay damages to the appellant.

Re : Question No.(i) and (ii)

14. Consent in the context of a doctor-patient relationship, means the 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. For example, when a patient enters a Dentist’s clinic and sits in the Dental chair, his consent is implied for examination, diagnosis and consultation. Except where consent can be clearly and obviously implied, there should be express consent. There is, however, a significant difference in the nature of express consent of the patient, known as ’real consent’ in UK and as ’informed consent’ in America. In UK, the elements of consent are defined with reference to the patient and a consent is considered to be valid and ’real’ when (i) the patient gives it voluntarily without any coercion; (ii) the patient has the capacity and competence to give consent;

and (iii) the patient has the minimum of adequate level of information about the nature of the procedure to which he is consenting to. On the other hand, the concept of 'informed consent' developed by American courts, while retaining the basic requirements consent, shifts the emphasis to the doctor's duty to disclose the necessary information to the patient to secure his consent. 'Informed consent' is defined in Taber's Cyclopedic Medical Dictionary thus :

"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; 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."

In Canterbury v. Spence - 1972 [464] Federal Reporter 2d. 772, the United States Courts of appeals, District of Columbia Circuit, emphasized the element of Doctor's duty in 'informed consent' thus:
"It is well established that the physician must seek and secure his patient's consent before commencing an operation or other course of treatment. It is also clear that the consent, to be efficacious, must be free from imposition upon the patient. It is the settled rule that therapy not authorized by the patient may amount to a tort - a common law battery - by the physician. And it is evident that it is normally impossible to obtain a consent worthy of the name unless the physician first elucidates the options and the perils for the patient's edification. Thus the physician has long borne a duty, on pain of liability for unauthorized treatment, to make adequate disclosure to the patient."

[Emphasis supplied]

15. The basic principle in regard to patient's consent may be traced to the following classic statement by Justice Cardozo in Schoendorff vs. Society of New York Hospital - (1914) 211 NY 125 :
'Every human being of adult years and sound mind has a right to determine what should be done with his body; and a surgeon who performs the operation without his patient's consent, commits an assault for which he is liable in damages."

This principle has been accepted by English court also. In Re : F. 1989(2) All ER 545, the House of Lords while dealing with a case of sterilization of a mental patient reiterated the fundamental principle that every person's body is inviolate and performance of a medical operation on a person without his or her consent is unlawful. The English law on this aspect is summarised thus in Principles of Medical Law (published by Oxford University Press -- Second Edition, edited by Andrew Grubb, Para 3.04, Page 133) :
"Any intentional touching of a person is unlawful and amounts to the tort of battery unless it is justified by consent or other lawful authority. In medical law, this means that a doctor may only carry out a medical treatment or procedure which involves contact with a patient if there exists a valid consent by the patient (or another person authorized by law to consent on his behalf) or if the touching is permitted notwithstanding the absence of consent."

16. The next question is whether in an action for negligence/battery for performance of an unauthorized surgical procedure, the Doctor can put forth as defence the consent given for a particular operative procedure, as consent for any additional or further operative procedures performed in

the interests of the patient. In Murray vs. McMurchy - 1949 (2) DLR 442, the Supreme Court of BC, Canada, was considering a claim for battery by a patient who underwent a caesarian section. During the course of caesarian section, the doctor found fibroid tumors in the patient's uterus. Being of the view that such tumours would be a danger in case of future pregnancy, he performed a sterilization operation. The court upheld the claim for damages for battery. It held that sterilization could not be justified under the principle of necessity, as there was no immediate threat or danger to the patient's health or life and it would not have been unreasonable to postpone the operation to secure the patient's consent. The fact that the doctor found it convenient to perform the sterilization operation without consent as the patient was already under general anaesthetic, was held to be not a valid defence. A somewhat similar view was expressed by Courts of Appeal in England in Re : F. (supra). It was held that the additional or further treatment which can be given (outside the consented procedure) should be confined to only such treatment as is necessary to meet the emergency, and as such needs to be carried out at once and before the patient is likely to be in a position to make a decision for himself. Lord Goff observed :

"Where, for example, a surgeon performs an operation without his consent on a patient temporarily rendered unconscious in an accident, he should do no more than is reasonably required, in the best interests of the patient, before he recovers consciousness. I can see no practical difficulty arising from this requirement, which derives from the fact that the patient is expected before long to regain consciousness and can then be consulted about longer term measures."

The decision in Marshell vs. Curry - 1933 (3) DLR 260 decided by the Supreme Court of NS, Canada, illustrates the exception to the rule, that an unauthorized procedure may be justified if the patient's medical condition brooks no delay and warrants immediate action without waiting for the patient to regain consciousness and take a decision for himself. In that case the doctor discovered a grossly diseased testicle while performing a hernia operation. As the doctor considered it to be gangrenous, posing a threat to patient's life and health, the doctor removed it without consent, as a part of the hernia operation. An action for battery was brought on the ground that the consent was for a hernia operation and removal of testicle was not consent. The claim was dismissed. The court was of the view that the doctor can act without the consent of the patient where it is necessary to save the life or preserve the health of the patient. Thus, the principle of necessity by which the doctor is permitted to perform further or additional procedure (unauthorized) is restricted to cases where the patient is temporarily incompetent (being unconscious), to permit the procedure delaying of which would be unreasonable because of the imminent danger to the life or health of the patient.

17. It is quite possible that if the patient been conscious, and informed about the need for the additional procedure, the patient might have agreed to it. It may be that the additional procedure is beneficial and in the interests of the patient. It may be that postponement of the additional procedure (say removal of an organ) may require another surgery, whereas removal of the affected organ during the initial diagnostic or exploratory surgery, would save the patient from the pain and cost of a second operation. Howsoever practical or convenient the reasons may be, they are not relevant. What is relevant and of importance is the inviolable nature of the patient's right in regard to his body and his right to decide whether he should undergo the particular treatment or surgery or not. Therefore at the risk of repetition, we may add that unless the unauthorized additional or further procedure is necessary in order to save the life or preserve the health of the patient and it would be unreasonable (as contrasted from being merely inconvenient) to delay the further procedure until the patient regains consciousness and takes a decision, a

doctor cannot perform such procedure without the consent of the patient.

18. We may also refer to the code of medical ethics laid down by the Medical Council of India (approved by the Central Government under section 33 of Indian Medical Council Act, 1956). It contains a chapter relating to disciplinary action which enumerates a list of responsibilities, violation of which will be professional misconduct. Clause 13 of the said chapter places the following responsibility on a doctor :

"13. Before performing an operation the physician should obtain in writing the consent from the husband or wife, parent or guardian in the case of a minor, or the patient himself as the case may be. In an operation which may result in sterility the consent of both husband and wife is needed."

We may also refer to the following guidelines to doctors, issued by the General Medical Council of U.K. in seeking consent of the patient for investigation and treatment :

"Patients have a right to information about their condition and the treatment options available to them. The amount of information you give each patient will vary, according to factors such as the nature of the condition, the complexity of the treatment, the risks associated with the treatment or procedure, and the patient's own wishes. For example, patients may need more information to make an informed decision about the procedure which carries a high risk of failure or adverse side effects; or about an investigation for a condition which, if present, could have serious implications for the patient's employment, social or personal life.

x x x x x

You should raise with patients the possibility of additional problems coming to light during a procedure when the patient is unconscious or otherwise unable to make a decision. You should seek consent to treat any problems which you think may arise and ascertain whether there are any procedures to which the patient would object, or prefer to give further thought before you proceed."

The Consent form for Hospital admission and medical treatment, to which appellant's signature was obtained by the respondent on 10.5.1995, which can safely be presumed to constitute the contract between the parties, specifically states :
"(A) It is customary, except in emergency or extraordinary circumstances, that no substantial procedures are performed upon a patient unless and until he or she has had an opportunity to discuss them with the physician or other health professional to the patient's satisfaction.

(B) Each patient has right to consent, or to refuse consent, to any proposed procedure of therapeutic course."

19. We therefore hold that in Medical Law, where a surgeon is consulted by a patient, and consent of the patient is taken for diagnostic procedure/surgery, such consent cannot be considered as authorisation or permission to perform therapeutic surgery either conservative or radical (except in life threatening or emergent situations). Similarly where the consent by the patient is for a particular operative surgery, it cannot be treated as consent for an unauthorized additional procedure involving removal of an organ, only on the ground that such removal is beneficial to the patient or is likely to prevent some danger developing in future, where there is no imminent danger to the life or health of the patient.

20. We may next consider the nature of information that is required to be furnished by a Doctor to secure a valid or real consent. In Bowater v. Rowley Regis Corporation - [1944] 1 KB 476, Scott L.J. observed :
"A man cannot be said to be truly 'willing' unless he is in a position to choose freely, and freedom of choice predicates, not only full knowledge of the circumstances on which the exercise of choice is conditioned, so that he may be able to choose wisely, but the absence from his mind of any feeling of constraint so that nothing shall interfere with the freedom of his will."

In Salgo vs. Leland Stanford [154 Cal. App. 2d.560 (1957)], it was held that 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 proposed treatment.

21. Canterbury (supra) explored the rationale of a Doctor's duty to reasonably inform a patient as to the treatment alternatives available and the risk incidental to them, as also the scope of the disclosure requirement and the physician's privileges not to disclose. It laid down the 'reasonably prudent patient test' which required the doctor to disclose all material risks to a patient, to show an 'informed consent'. It was held :
"True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each. The average patient has little or no understanding of the medical arts, and ordinarily has only his physician to whom he can look for enlightenment with which to reach an intelligent decision. From these almost axiomatic considerations springs the need, and in turn the requirement, of a reasonable divulgence by physician to patient to make such a decision possible.

\005Just as plainly, due care normally demands that the physician warn the patient of any risks to his well being which contemplated therapy may involve.

The context in which the duty of risk-disclosure arises is invariably the occasion for decision as to whether a particular treatment procedure is to be undertaken. 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. To enable the patient to chart his course understandably, some familiarity with the therapeutic alternatives and their hazards becomes essential\005\005\005

A reasonable revelation in these respects is not only a necessity but, as we see it, is as much a matter of the physician's duty. It is a duty to warn of the dangers lurking in the proposed treatment, and that is surely a facet of due care. It is, too, a duty to impart information which the patient has every right to expect. The patient's reliance upon the physician is a trust of the kind which traditionally has exacted obligations beyond those associated with arms length transactions. His dependence upon the physician for information affecting his well-being, in terms of contemplated treatment, is well-nigh abject\005\005. we ourselves have found "in the fiducial qualities of (the physician-patient) relationship the physician's duty to reveal to the patient that which in his best interests it is important that he should know." We now find, as a part of the physician's overall obligation to the patient, a similar duty of reasonable disclosure of the choices with respect to proposed therapy and the dangers inherently and potentially involve.

In our view, the patient's right of self-decision shapes the boundaries of the duty to reveal. That right can be effectively exercised only if the

patient possesses enough information to enable an intelligent choice. The scope of the physician's communications to the patient, then, must be measured by the patient's need, and that need is the information material to the decision. Thus the test for determining whether a particular peril must be divulged is its materially to the patient's decision : all risks potentially affecting the decision must be unmasked. "

It was further held that a risk is material 'when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy'. The doctor, therefore, is required to communicate all inherent and potential hazards of the proposed treatment, the alternatives to that treatment, if any, and the likely effect if the patient remained untreated. This stringent standard of disclosure was subjected to only two exceptions : (i) where there was a genuine emergency, e.g. the patient was unconscious; and (ii) where the information would be harmful to the patient, e.g. where it might cause psychological damage, or where the patient would become so emotionally distraught as to prevent a rational decision. It, however, appears that several States in USA have chosen to avoid the decision in Canterbury by enacting legislation which severely curtails operation of the doctrine of informed consent.

22. The stringent standards regarding disclosure laid down in Canterbury, as necessary to secure an informed consent of the patient, was not accepted in the English courts. In England, standard applicable is popularly known as the Bolam Test, first laid down in Bolam v. Friern Hospital Management Committee - [1957] 2 All.E.R. 118. McNair J., in a trial relating to negligence of a medical practitioner, while instructing the Jury, stated thus :

"(i) A doctor is not negligent, if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. \005\005 Putting it the other way round, a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view. At the same time, that does not mean that a medical man can obstinately and pig-headedly 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.

(ii) When a doctor dealing with a sick man strongly believed that the only hope of cure was submission to a particular therapy, he could not be criticized if, believing the danger involved in the treatment to be minimal, did not stress them to the patient.

(iii) In order to recover damages for failure to give warning the plaintiff must show not only that the failure was negligent but also that if he had been warned he would not have consented to the treatment.

23. Hunter v. Hanley (1955 SC 200), a Scottish case is also worth noticing. In that decision, Lord President Clyde held :
"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."

He also laid down the following requirements to be established by a patient to fasten liability on the ground of want of care or negligence on

the part of the doctor :
"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."

24. In Sidaway v. Bethlem Royal Hospital Governors & Ors. [1985] 1 All ER 643, the House of Lords, per 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 that case the defendant, a surgeon, warned the plaintiff of the possibility of disturbing a nerve root while advising an operation on the spinal column to relieve shoulder and neck pain. He did not however mention the possibility of damage to the spinal cord. Though the operation was performed without negligence, the plaintiff sustained damage to spinal cord resulting in partial paralysis. The plaintiff alleged that defendant was negligent in failing to inform her about the said risk and that had she known the true position, she would not have accepted the treatment. The trial Judge and Court of Appeal applied the Bolam test and concluded that the defendant had acted in accordance with a practice accepted as proper by a responsible body of medical opinion, in not informing the plaintiff of the risk of damage to spinal cord. Consequently, the claim for damages was rejected. 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, was not the appropriate test of liability for negligence, under English law. The majority were of the view that the test of liability in respect of a doctor's duty to warn his patient of risks inherent in treatment recommended by him was the same as the test applicable to diagnosis and treatment, namely, that the doctor was required to act in accordance with the practice accepted at the time as proper by a responsible body of medical opinion. Lord Diplock stated:
"In English jurisprudence the doctor's relationship with his patient which gives rise to the normal duty of care to exercise his skill and judgment to improve the patient's health in any particular respect in which the patient has sought his aid has hitherto been treated as a single comprehensive duty covering all the ways in which a doctor is called on to exercise his skill and judgment in the improvement of the physical or mental condition of the patient for which his services either as a general practitioner or as a specialist have been engaged. This general duty is not subject to dissection into a number of component parts to which different criteria of what satisfy the duty of care apply, such as diagnosis, treatment and advice (including warning of any risks of something going wrong however skillfully the treatment advised is carried out). The Bolam case itself embraced failure to advise the patient of the risk involved in the electric shock treatment as one of the allegations of negligence against the surgeon as well as negligence in the actual carrying out of treatment in which that risk did result in injury to the patient. The same criteria were applied to both these aspects of the surgeon's duty of care. In modern medicine and surgery such dissection of the various things a doctor has to do in the exercise of his whole duty of care owed to his patient is neither legally meaningful nor medically practicable\005.\005 To decide what risks the existence of which a patient should be voluntarily warned and the terms in which such warning, if any, should be given, having regard to the effect that the warning may have, is as much an exercise of professional skill and judgment as any other part of the doctor's comprehensive duty of care to the individual patient, and expert medical evidence on this matter should be treated in just the same way. The Bolam test should be applied."

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 for three principal reasons. First, it gives insufficient weight to the realities of the doctor/patient relationship. A very wide variety of factors must enter into a doctor's clinical judgment not only as to what treatment is appropriate for a particular patient, but also as to how best to communicate to the patient the significant factors necessary to enable the patient to make an informed decision whether to undergo the treatment. The doctor cannot set out to educate the patient to his own standard of medical knowledge of all the relevant factors involved. He may take the view, certainly with some patients, that the very fact of his volunteering, without being asked, information of some remote risk involved in the treatment proposed, even though he described it as remote, may lead to that risk assuming an undue significance in the patient's calculations. Second, it would seem to me quite unrealistic in any medical negligence action to confine the expert medical evidence to an explanation of the primary medical factors involved and to deny the court the benefit of evidence of medical opinion and practice on the particular issue of disclosure which is under consideration. Third, the objective test which Canterbury propounds seems to me to be so imprecise as to be almost meaningless. If it is to be left to individual judges to decide for themselves what "a reasonable person in the patient's position' would consider a risk of sufficient significance that he should be told about it, the outcome of litigation in this field is likely to be quite unpredictable."

Lord Bridge however made it clear that when questioned specifically by the patient about the risks involved in a particular treatment proposed, the doctor's duty is to answer truthfully and as fully as the questioner requires. He further held that remote risk of damage (referred to as risk at 1 or 2%) need not be disclosed but if the risk of damage is substantial (referred to as 10% risk), it may have to be disclosed. Lord Scarman, in minority, was inclined to adopt the more stringent test laid down in Canterbury.

25. In India, Bolam test has broadly been accepted as the general rule. We may refer three cases of this Court. In Achutrao Haribhau Khodwa vs. State of Maharastra - 1996 (2) SCC 634, this Court held :
"The skill of medical practitioners differs from doctor to doctor. The nature of the profession is such that there may be more than one course of treatment which may be advisable for treating a patient. Courts would indeed be slow in attributing negligence on the part of a doctor if he has performed his duties to the best of his ability and with due care and caution. Medical opinion may differ with regard to the course of action to be taken by a doctor treating a patient, but as long as a doctor acts in a manner which is acceptable to the medical profession and the Court finds that he has attended on the patient with due care skill and diligence and if the patient still does not survive or suffers a permanent ailment, it would be difficult to hold the doctor to be guilty of negligence\005\005\005..In cases where the doctors act carelessly and in a manner which is not expected of a medical practitioner, then in such a case an action in torts would be maintainable."

In Vinitha Ashok vs. Lakshmi Hospital - 2001 (8) SCC 731, this Court after referring to Bolam, Sidaway and Achutrao, clarified:
"A 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.

In Indian Medical Association vs. V. P. Shantha - 1995 (6) SCC 651, this Court held :
"The approach of the courts is to require that professional men should possess a certain minimum degree of competence and that they should exercise reasonable care in the discharge of their duties. In general, a professional man owes to his client a duty in tort as well as in contract to exercise reasonable care in giving advice or performing services".

Neither Achutrao nor Vinitha Ashok referred to the American view expressed in Canterbury.

26. In India, 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. Many poor patients with serious ailments (eg. heart patients and cancer patients) have to wait for months for their turn even for diagnosis, and due to limited treatment facilities, many die even before their turn comes for treatment. What choice do these poor patients have? Any treatment of whatever degree, is a boon or a favour, for them. The stark reality is that for a vast majority in the country, the concepts of informed consent or any form of consent, and choice in treatment, have no meaning or relevance.

The position of doctors in Government and charitable hospitals, who treat them, is also unenviable. They are overworked, understaffed, with little or no diagnostic or surgical facilities and limited choice of medicines and treatment procedures. They have to improvise with virtual non-existent facilities and limited dubious medicines. They are required to be committed, service oriented and non-commercial in outlook. What choice of treatment can these doctors give to the poor patients? What informed consent they can take from them?

27. On the other hand, we have the Doctors, hospitals, nursing homes and clinics in the private commercial sector. 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 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.

28. But unfortunately not all doctors in government hospitals are paragons of service, nor fortunately, all private hospitals/doctors are commercial minded. There are many a doctor in government hospitals

who do not care about patients and unscrupulously insist upon 'unofficial' payment for free treatment or insist upon private consultations. On the other hand, many private hospitals and Doctors give the best of treatment without exploitation, at a reasonable cost, charging a fee, which is resonable recompense for the service rendered. Of course, some doctors, both in private practice or in government service, look at patients not as persons who should be relieved from pain and suffering by prompt and proper treatment at an affordable cost, but as potential income-providers/ customers who can be exploited by prolonged or radical diagnostic and treatment procedures. It is this minority who bring a bad name to the entire profession.

29. Health care (like education) can thrive in the hands of charitable institutions. It also requires more serious attention from the State. In a developing country like ours where teeming millions of poor, downtrodden and illiterate cry out for health-care, there is a desperate need for making health-care easily accessible and affordable. Remarkable developments in the field of medicine might have revolutionalized health care. But they cannot be afforded by the common man. The woes of non-affording patients have in no way decreased. Gone are the days when any patient could go to a neighbourhood general practitioner or a family doctor and get affordable treatment at a very reasonable cost, with affection, care and concern. Their 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 who can identify the problem and provide treatment. What used to be competent treatment by one General Practitioner has now become multi-pronged treatment by several specialists. Law stepping in to provide remedy for negligence or deficiency in service by medical practioners, has its own twin adverse effects. 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, even though they might have already identified the ailment with reference to the symptoms and medical history with 90% certainly, by their knowledge and experience. Secondly 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. As a consequence, it is now common that a comparatively simple ailment, which earlier used to be treated at the cost of a few rupees by consulting a single doctor, requires an expense of several hundred or thousands on account of four factors : (i) commercialization of medical treatment; (ii) increase in specialists as contrasted from general practitioners and the need for consulting more than one doctor; (iii) varied diagnostic and treatment procedures at high cost; and (iv) need for doctors to have insurance cover. The obvious, may be naove, answer to unwarranted diagnostic procedures and treatment and prohibitive cost of treatment, is an increase in the participation of health care by the state and charitable institutions. An enlightened and committed medical profession can also provide a better alternative. Be that as it may. We are not trying to intrude on matters of policy, nor are we against proper diagnosis or specialisation. We are only worried about the enormous hardship and expense to which the common man is subjected, and are merely voicing the concern of those who are not able to fend for themselves. We will be too happy if what we have observed is an overstatement, but our intuition tells us that it is an understatement.

30. What we are considering in this case, is not the duties or obligations of doctors in government charitable hospitals where treatment is free or on actual cost basis. We are concerned with doctors in private practice and hospitals and nursing homes run commercially, where the relationship of doctors and patients are contractual in origin, the service is in consideration of a fee paid by the patient, where the contract implies

that the professional men possessing a minimum degree of competence would exercise reasonable care in the discharge of their duties while giving advice or treatment.

31. There is a need to keep the cost of treatment within affordable limits. Bringing in the American concepts and standards of treatment procedures and disclosure of risks, consequences and choices will inevitably bring in higher cost-structure of American medical care. Patients in India cannot afford them. People in India still have great regard and respect for Doctors. The Members of medical profession have also, by and large, shown care and concern for the patients. There is an atmosphere of trust and implicit faith in the advice given by the Doctor. The India psyche rarely questions or challenges the medical advice. Having regard to the conditions obtaining in India, as also the settled and recognized practices of medical fraternity in India, we are of the view that to nurture the doctor-patient relationship on the basis of trust, the extent and nature of information required to be given by doctors should continue to be governed by the Bolam test rather than the 'reasonably prudential patient' test evolved in Canterbury. It is for the doctor to decide, with reference to the condition of the patient, nature of illness, and the prevailing established practices, how much information regarding risks and consequences should be given to the patients, and how they should be couched, having the best interests of the patient. A doctor cannot be held negligent either in regard to diagnosis or treatment or in disclosing the risks involved in a particular surgical procedure or treatment, if the doctor has acted with normal care, in accordance with a recognised practices accepted as proper by a responsible body of medical men skilled in that particular field, even though there may be a body of opinion that takes a contrary view. Where there are more than one recognized school of established medical practice, it is not negligence for a doctor to follow any one of those practices, in preference to the others.

32. We may now summarize 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 should be on the basis of adequate information concerning the nature of the treatment procedure, so that he knows what 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 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.

(iii) 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 battery. The only exception to this rule is where the additional procedure though unauthorized, is necessary in order to save the life or preserve the health of the patient and it would be unreasonable to delay such unauthorized procedure until patient regains consciousness and takes a decision.

(iv) There can be a common consent for diagnostic and operative procedures where they are contemplated. There can also be a common consent for a particular surgical procedure and an additional or further procedure that may become necessary during the course of surgery.

(v) 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 will depend upon the physical and mental condition of the patient, the nature of treatment, and the risk and consequences attached to the treatment.

33. We may note here that courts in Canada and Australia have moved towards Canterbury standard of disclosure and informed consent - vide Reibl v. Hughes (1980) 114 DLR (3d.) 1 decided by the Canadian Supreme Court and Rogers v. Whittaker - 1992 (109) ALR 625 decided by the High Court of Australia. Even in England there is a tendency to make the doctor's duty to inform more stringent than Bolam's test adopted in Sidaway. Lord Scarman's minority view in Sidaway favouring Canterbury, in course of time, may ultimately become the law in England. A beginning has been made in Bolitho v. City and Hackney HA - 1998 1 AC 232 and Pearce v. United Bristol Healthcare NHS Trust 1998 (48) BMLR 118. We have however, consciously preferred the 'real consent' concept evolved in Bolam and Sidaway in preference to the 'reasonably prudent patient test' in Canterbury, having regard to the ground realities in medical and health-care in India. But 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, inevitably, a day may come when we may have to move towards Canterbury. But not for the present.

Re : Question No.(iii)

34. 'Gynaecology' (second edition) edited by Robert W. Shah, describes 'real consent' with reference to Gynaecologists (page 867 et seq) as follows :

"An increasingly important risk area for all doctors is the question of consent. No-one may lay hands on another against their will without running the risk of criminal prosecution for assault and, if injury results, a civil action for damages for trespass or negligence. In the case of a doctor, consent to any physical interference will readily be implied; a woman must be assumed to consent to a normal physical examination if she consults a gynaecologist, in the absence of clear evidence of her refusal or restriction of such examination. The problems arise when the gynaecologist's intervention results in unfortunate side effects or permanent interference with a function, whether or not any part of the body is removed. For example, if the gynaecologist agrees with the patient to perform a hysterectomy and

removes the ovaries without her specific consent, that will be a trespass and an act of negligence. The only available defence will be that it was necessary for the life of the patient to proceed at once to remove the ovaries because of some perceived pathology in them.

What is meant by consent? The term 'informed consent' is often used, but there is no such concept in English law. The consent must be real : that is to say, the patient must have been given sufficient information for her to understand the nature of the operation, its likely effects, and any complications which may arise and which the surgeon in the exercise of his duty to the patient considers she should be made aware of; only then can she reach a proper decision. But the surgeon need not warn the patient of remote risks, any more than an anaesthetist need warn the patient that a certain small number of those anaesthetized will suffer cardiac arrest or never recover consciousness. Only where there is a recognized risk, rather than a rare complication, is the surgeon under an obligation to warn the patient of that risk. He is not under a duty to warn the patient of the possible results of hypothetical negligent surgery. ..

In advising an operation, therefore, the doctor must do so in the way in which a competent gynaecologist exercising reasonable skill and care in similar circumstances would have done. In doing this he will take into account the personality of the patient and the importance of the operation to her future well being. It may be good practice not to warn a very nervous patient of any possible complications if she requires immediate surgery for, say, a malignant condition. The doctor must decide how much to say to her taking into account his assessment of her personality, the questions she asks and his view of how much she understands. If the patient asks a direct question, she must be given a truthful answer. \005 To take the example of hysterectomy : although the surgeon will tell the patient that it is proposed to remove her uterus and perhaps her ovaries, and describe what that will mean for her future well being (sterility, premature menopause), she will not be warned of the possibility of damage to the ureter, vesicovaginal fistula, fatal haemorrhage or anaesthetic death."

35. The specific case of the appellant was that she got herself admitted on 10.5.1995 only for a diagnostic laparoscopy; that she was not informed either on 9th or 10th that she was suffering from endometriosis or that her reproductive organs had to be removed to cure her from the said disease; that her consent was not obtained for the removal of her reproductive organs; and that when she was under general anaesthesia for diagnostic laparoscopy, respondent came out of the operation theatre and informed her aged mother that the patient was bleeding profusely which might endanger her life and hysterectomy was the only option to save her life, and took her consent.

36. The respondent on the other hand contends that on the basis of clinical and ultra sound examination on 9.5.1995, she had made a provisional diagnosis of endometriosis; that on same day, she informed the complainant and her mother separately, that she would do a diagnostic laparoscopy on the next day and if the endometric lesion was found to be mild or moderate, she will adopt a conservative treatment by operative laparoscopy, but if the lesion was extensive then considering her age and extent of lesion and likelihood of destruction of the functions of the tube, a laparotomy would be done; that the appellant was admitted to the hospital for diagnostic and operative laparoscopy and laparotomy and appellant's consent was obtained for such procedures; that the decision to operate and remove the uterus and ovaries was not sudden, nor on account of any emergent situation developing during laproscopy; and that the radical surgery was authorized, as it was preceded by a valid consent. She also contends that as the appellant wanted a permanent cure, the decision to conduct a hysterectomy was medically correct and the

surgical procedure in fact cured the appellant and saved her intestines, bladder and ureter being damaged due to extension of the lesion. She had also tried to justify the surgical removal of the uterus and ovaries, with reference to the age and medical condition of the complainant.

37. The summery of the surgical procedure (dictated by respondent and handwritten by her assistant Dr. Lata Rangan) furnished to the appellant also confirms that no emergency or life threatening situation developed during laparoscopy. This is reiterated in the evidence of respondent and Dr. Lata Rangan. In her affidavit dated 16.2.2002 filed by way of examination-in-chief, the respondent stated :
"15. The laproscopic examination revealed a frozen pelvis and considering the extent of the lesion it was decided that conservative surgery was not advisable and the nature of the problem required for its cure hysterectomy.

16. When the Deponent decided to perform hysterectomy she told Dr. Lata to intimate the mother of Ms. Samira Kohli of the fact that hysterectomy was going to be performed on her. No complications had arisen in the operation theatre and the procedure being performed was in terms of the consent given by Ms. Samira Kohli herself."

In her affidavit dated 16.2.2002 filed by way of examination-in-chief, Dr. Lata Rangan stated:
"14. I was in the Operation Theatre alongwith Dr. Prabha Manchanda. The laproscopic examination revealed a frozen pelvis and considering the extent of the lesion it was decided that conservative surgery was not possible and that the nature of the problem required performance of hysterectomy.

15. When it was decided to perform hysterectomy the deponent was told by Dr. Prabha Manchanda to intimate the mother of Ms. Samira Kohli of the fact that hysterectomy was now going to be performed on her. No complications had arisen in the Operation Theatre and the procedure conducted therein was in terms of the consent given by Ms. Samira Kohli herself. I got the mother to sign the Form too so that the factum of intimation was duly documented."

Thus, the respondent’s definite case is that on 9.5.1995, the respondent had provisionally diagnosed endometriosis and informed the appellant; that appellant had agreed that hysterectomy may be performed if the lesion was extensive; and that in pursuance of such consent, reiterated in writing by the appellant in the consent form on 10.5.1995, she performed the AH-BSO removing the uterus and ovaries on finding extensive endometriosis. In other words, according to respondent, the abdominal hysterectomy and bilateral salpingo-oopherectomy (AH-BSO) was not necessitated on account of any emergency or life threatening situation developing or being discovered when laparoscopic test was conducted, but according to an agreed plan, consented by the appellant and her mother on 9.5.1995 itself, reiterated in writing on 10.5.1995. Therefore the defence of respondent is one based on specific consent. Let us therefore examine whether there was consent.

38. The Admission and Discharge card maintained and produced by the respondent showed that the appellant was admitted "for diagnostic and (?)operative laparoscopy on 10.5.1995". The OPD card dated 9.5.1995 does not refer to endometriosis, which is also admitted by the respondent in her cross-examination. If fact, the respondent also admitted that the confirmation of diagnosis is possible only after laparoscopy test :
"On clinical and ultrasound examination a diagnosis can be made to some extent. But precise diagnosis will have to be on laparoscopy."

The consent form dated 10.5.1995 signed by the appellant states that

appellant has been informed that the treatment to be undertaken is "diagnostic and operative laparoscopy. Laparotomy may be needed." The case summary dictated by respondent and written by Dr. Lata Rangan also clearly says "admitted for Hysteroscopy, diagnostic laparoscopy and operative laparoscopy on 10.5.1995." (Note : Hysteroscopy is inspection of uterus by special endoscope and laproscopy is abdominal exploration by special endoscope.)

39. In this context, we may also refer to a notice dated 5.6.1995 issued by respondent to the appellant through counsel, demanding payment of Rs.39,325/- towards the bill amount. Paras 1, 3, and 4 are relevant which are extracted below :

"1. You were admitted to our clinic Dr. Manchanda, No.7, Ring Road, Lajpat Nagar, New Delhi for diagnostic and operative laparoscopy and Endometrial biopsy on 10.5.1995." \005\005\005..

"3. The findings of laparoscopy were : a very extensive lesion of the endometriosis with pools of blood, extensive adherence involving the tubes of the uterus and ovaries, a chocolate cyst in the right ovary and areas of endometriosis on the surface of the left ovary but no cyst."

"4. The findings were duly conveyed to Ms. Somi Kohli who was also shown a video recording of the lesion. You and Mrs. Somi Kohli were informed that conservative surgery would be futile and removal of the uterus and more extensive surgery, considering your age and extensive lesion and destruction of the functions of the tubes, was preferable."

This also makes it clear that the appellant was not admitted for conducting hysterectomy or bilateral salpingo-oopherectomy, but only for diagnostic purposes. We may, however, refer to a wrong statement of fact made in the said notice. It states that on 10.5.1995 after conducting a laparoscopic examination, the video-recording of the lesion was shown to appellant’s mother, and the respondent informed the appellant and her mother that conservative surgery would be futile and removal of uterus and more extensive surgery was preferable having regard to the more extensive lesion and destruction of the function of the tubes. But this statement cannot be true. The extensive nature of lesion and destruction of the functions obviously became evident only after diagnostic laparoscopy. But after diagnostic laparoscopy and the video recording of the Lesion, there was no occasion for respondent to inform anything to appellant. When the laparoscopy and video recording was made, the appellant was already unconscious. Before she regained consciousness, AH-BSO was performed removing her uterus and ovaries. Therefore, the appellant could not have been informed on 10.5.1995 that conservative surgery would be futile and removal of uterus and extensive surgery was preferable in view of the extensive lesion and destruction of the function of the tubes did not arise.

40. The admission card makes it clear that the appellant was admitted only for diagnostic and operative laparoscopy. It does not refer to laparotomy. The consent form shows that the appellant gave consent only for diagnostic operative laparoscopy, and laparotomy if needed. Laparotomy is a surgical procedure to open up the abdomen or an abdominal operation. It refers to the operation performed to examine the abdominal organs and aid diagnosis. Many a time, after the diagnosis is made and the problem is identified it may be fixed during the laparotomy itself. In other cases, a subsequent surgery may be required. Laparotomy can no doubt be either a diagnostic or therapeutic. In the former, more often referred to as the exploratory laparotomy, an exercise is undertaken to identify the nature of the disease. In the latter, a therapeutic laparatomy is conducted after the cause has been identified. When a specific operation say hysterectomy or salpingo-oopherectomy is planned,

laparotomy is merely the first step of the procedure, followed by the actual specific operation, namely hysterectomy or salpingo-oopherectomy. Depending upon the incision placement, laparotomy gives access to any abdominal organ or space and is the first step in any major diagnostic or therapeutic surgical procedure involving a) the lower port of the digestive tract, b) liver, pancreas and spine, c) bladder, d) female reproductive organs and e) retroperitonium. On the other hand, hysterectomy and slapingo-oopherectomy follow laparotomy and are not themselves referred to as laparotomy. Therefore, when the consent form refers to diagnostic and operative laparoscopy and "laparotomy if needed", it refers to a consent for a definite laparoscopy with a contingent laparotomy if needed. It does not amount to consent for OH-BSO surgery removing the uterus and ovaries/fallopian tubes. If the appellant had consented for a OH-BSO then the consent form would have given consent for "diagnostic and operative laparoscopy. Laparotomy, hysterectomy and bilateral salpingo-oopherectomy, if needed."

41. On the documentary evidence and the histopathology report the appellant also raised an issue as to whether appellant was suffering from endometriosis at all. She points out that ultra-sound did not disclose endometriosis and the histopathology report does not confirm endometriosis. The respective experts examined on either side have expressed divergent views as to whether appellant was suffering from endometriosis. It may not be necessary to give a definite finding on this aspect, as the real question for consideration is whether appellant gave consent for hysterectomy and bilateral salpingo-oopherectomy and not whether appellant was suffering from endometriosis. Similarly there is divergence of expert opinion as to whether removal of uterus and ovaries was the standard or recognized remedy even if there was endometriosis and whether conservative treatment was an alternative. Here again it is not necessary to record any finding as to which is the proper remedy. It is sufficient to note that there are different modes of treatment favoured by different schools of thought among Gynaecologists.

42. Respondent contended that the term ’laparotomy’ is used in the consent form (by her assistant Dr. Lata Rangan) is equal to or same as hysterectomy. The respondent’s contention that ’Laparotomy’ refers to and includes hystectomy and bilateral salpingo-oopherectomy cannot be accepted. The following clear evidence of appellant’s expert witness -- Dr. Puneet Bedi (CW 1) is not challenged in cross examination :
"Laparotomy is opening up of the abdomen which is quite different from hysterectomy. Hysterectomy is a procedure which involves surgical removal of uterus. The two procedures are totally different and consent for each procedure has to be obtained separately."

On the other hand, the evidence of respondent’s expert witness (Dr. Sudha Salhan) on this question is evasive and clearly implies laparotomy is not the same as hysterectomy. The relevant portion of her evidence is extracted below :

"Q. As per which medical authority, laparotomy is equal to hysterectomy?

Ans. Consent for laparotomy permits undertaking for such surgical procedure necessary to treat medical conditions including hysterectomy.

Q. I put it to you that the medical practice is to take specific consent for hysterectomy.

Ans. Whenever we do hysterectomy only, specific consent is obtained."

43. Medical texts and authorities clearly spell out that Laparotomy is at best the initial step that is necessary for performing hysterectomy or salpingo-oopherectomy. Laparotomy by itself is not hysterectomy or salpingo-oopherectomy. Nor does 'hysterectomy' include salpingo-oopherectomy, in the case of woman who has not attained menopause. Laparotomy does not refer to surgical removal of any vital or reproductive organs. Laparotomy is usually exploratory and once the internal organs are exposed and examined and the disease or ailment is diagnosed, the problem may be addressed and fixed during the course of such laparotomy (as for example, removal of cysts and fulguration of endometric area as stated by respondent herself as a conservative form of treatment). But Laparotomy is never understood as referring to removal of any organ. In medical circles, it is well recognized that a catch all clause giving the surgeon permission to do anything necessary does not give roving authority to remove whatever he fancies may be for the good of the patient. For example, a surgeon cannot construe a consent to termination of pregnancy as a consent to sterilize the patient.

44. When the oral and documentary evidence is considered in the light of the legal position discussed above while answering questions (i) and (ii), it is clear that there was no consent by the appellant for conducting hysterectomy and bilateral salpingo-oopherectomy.

45. The Respondent next contended that the consent given by the appellant's mother for performing hysterectomy should be considered as valid consent for performing hysterectomy and salpingo-oopherectomy. The appellant was neither a minor, nor mentally challenged, nor incapacitated. When a patient is a competent adult, there is no question of someone else giving consent on her behalf. There was no medical emergency during surgery. The appellant was only temporarily unconscious, undergoing only a diagnostic procedure by way of laparoscopy. The respondent ought to have waited till the appellant regained consciousness, discussed the result of the laparoscopic examination and then taken her consent for the removal of her uterus and ovaries. In the absence of an emergency and as the matter was still at the stage of diagnosis, the question of taking her mother's consent for radical surgery did not arise. Therefore, such consent by mother cannot be treated as valid or real consent. Further a consent for hysterectomy, is not a consent for bilateral salpingo - ooperectomy.

46. There is another facet of the consent given by the appellant's mother which requires to be noticed. The respondent's specific case is that the appellant had agreed for the surgical removal of uterus and ovaries depending upon the extent of the lesion. It is also her specific case that the consent by signing the consent form on 10.5.1995 wherein the treatment is mentioned as "diagnostic and operative laparoscopy. Laparotomy may be needed." includes the AH-BSO surgery for removal of uterus and ovaries. If the term 'laparotomy' is to include hysterectomy and salpingo-oopherectomy as contended by the respondent and there was a specific consent by the appellant in the consent form signed by her on 10.5.1995, there was absolutely no need for the respondent to send word through her assistant Dr. Lata Rangan to get the consent of appellant's mother for performing hysterectomy under general anesthesia. The very fact that such consent was sought from appellant's mother for conducting hysterectomy is a clear indication that there was no prior consent for hysterectomy by the appellant.

47. We may, therefore, summarize the factual position thus :

(i) On 9.5.1995 there was no confirmed diagnosis of endometriosis. The OPD slip does not refer to a provisional diagnosis of endometriosis on the basis of personal examination. Though there is a detailed reference to the findings of ultrasound in the entry relating to 9.5.1995 in the OPD slip, there is no reference to endometriosis which shows that ultrasound report did not show

endometriosis. In fact, ultra-sound may disclose fibroids, chocolate cyst or other abnormality which may indicate endometriosis, but cannot by itself lead to a diagnosis of endometriosis. This is evident from the evidence of CW1, RW1 and RW2 and recognized text books. In fact respondent's expert Dr. Sudha Salhan admits in her cross examination that endometriosis can only be suspected but not diagnosed by ultrasound and it can be confirmed only by laparoscopy. Even according to respondent, endometriosis was confirmed only by laparoscopy. [Books on "Gynaecology' clearly state : "The best means to diagnose endometriosis is by direct visualization at laparoscopy or laparotomy, with histological confirmation where uncertainty persists."] Therefore the claim of respondent that she had discussed in detail about endometriosis and the treatment on 9.5.1995 on the basis of her personal examination and ultra-sound report appears to be doubtful.

(ii) The appellant was admitted only for diagnostic laparoscopy (and at best for limited surgical treatment that could be made by laproscopy). She was not admitted for hysterectomy or bilateral salpingo-oopherectomy.

(iii) There was no consent by appellant for hysterectomy or bilateral salpingo-oopherectomy. The words "Laparotomy may be needed" in the consent form dated 10.5.1995 can only refer to therapeutic procedures which are conservative in nature (as for example removal of chocolate cyst and fulguration of endometric areas, as stated by respondent herself as a choice of treatment), and not radical surgery involving removal of important organs.

48. We find that the Commission has, without any legal basis, concluded that "the informed choice has to be left to the operating surgeon depending on his/her discretion, after assessing the damage to the internal organs, but subject to his/her exercising care and caution". It also erred in construing the words "such medical treatment as is considered necessary for me for\005\005." in the consent form as including surgical treatment by way of removal or uterus and ovaries. The Commission has also observed : "whether the uterus should have been removed or not or some other surgical procedure should have been followed are matters to be left to the discretion of the performing surgeon, as long as the surgeon does the work with adequate care and caution". This proceeds on the erroneous assumption that where the surgeon has shown adequate care and caution in performing the surgery, the consent of the patient for removal of an organ is unnecessary. The Commission failed to notice that the question was not about the correctness of the decision to remove the uterus and ovaries, but the failure to obtain the consent for removal of those important organs. There was a also faint attempt on the part of the respondent's counsel to contend that what were removed were not 'vital' organs and having regard to the advanced age of the appellant, as procreation was not possible, uterus and ovaries were virtually redundant organs. The appellant's counsel seriously disputes the position and contends that procreation was possible even at the age of 44 years. Suffice it to say that for a woman who has not married and not yet reached menopause, the reproductive organs are certainly important organs. There is also no dispute that removal of ovaries leads to abrupt menopause causing hormonal imbalance and consequential adverse effects.

Re : Question Nos.(iv) and (v) :

49. The case of the appellant is that she was not suffering from endometriosis and therefore, there was no need to remove the uterus and ovaries. In this behalf, she examined Dr. Puneet Bedi (Obstetrician and Gynaecologist) who gave hormone therapy to appellant for about two years prior to his examination in 2002. He stated that the best method to

diagnose endometriosis is diagnostic laparoscopy; that the presence of endometrial tissue anywhere outside the uterus is called Endometriosis; that the Histopathology report did not confirm endometriosis in the case of appellant; and that the mode of treatment for endometriosis would depend on the existing extent of the disease. He also stated that removal of uterus results in abrupt menopause. In natural menopause, which is a slow process, the body gets time to acclimatize to the low level of hormones gradually. On the other hand when the ovaries are removed, there is an abrupt stoppage of natural hormones and therefore Hormone Replacement Therapy is necessary to make up the loss of natural hormones. Hormone Replacement Therapy is also given even when there is a natural menopause. But hormone replacement therapy has side effects and complications. He also stated that on the basis of materials available on the file, he was of the view that Hysterectomy was not called for immediately. But if endometriosis had been proven from history and following diagnostic laparoscopy, hysterectomy could be considered as a last resort if all other medical methods failed. What is relevant from the evidence of Dr. Puneet Bedi, is that he does not say that hysterectomy is not the remedy for endometriosis, but only that it is a procedure that has to be considered as a last resort.

50. On the other hand, the respondent who is herself a experienced Obstetrician and Gynaecologist has given detailed evidence, giving the reasons for diagnosing the problem of appellant as endometriosis and has referred to in detail, the need for the surgery. She stated that having regard to the medical condition of complainant, her decision to perform hysterectomy was medically correct. The complainant wanted a cure for her problem and the AH-BSO surgery provided her such cure, apart from protecting her against any future damage to intestines, bladder and ureter. She explained that if the uterus and ovaries had not been removed there was a likelihood of lesion extending to the intestines causing bleedings, fibrosis and narrowing of the gut; the lesion could also go to the surface of the bladder penetrating the wall and causing haematuria and the ureter could be damaged due to fibrosis leading to damage of the kidney; there was also a chance of development of cancer also. She also pointed out that the complainant being 44 years of age, was in the pre-menopausal period and had menorrhagia which prevented regular ovulation which was necessary for pregnancy; that endometriosis also prevented fertilization and produced reaction in the pelvis which increased lymphocytes and macrophages which destroy the ova and sperm; and that the state of bodily health did not depend upon the existence of uterus and ovaries.

51. The respondent also examined Dr. Sudha Salhan, Professor and Head of Department (Obstetrics and Gynaecology) and President of the Association of Obstetricians and Gynaecologists of Delhi. Having seen the records relating to appellant including the record pertaining to clinical and ultra-sound examinations, she was of the view that the treatment given to appellant was correct and appropriate to appellant’s medical condition. She stated that the treatment is determined by severity of the disease and hysterectomy was not an unreasonable option as there was no scope left for fecundability in a woman aged 44 years suffering from endometriosis. She also stated that the histopathology report dated 15.5.1995 confirmed the diagnosis of endometriosis made by respondent. She also stated that she saw video-tape of the laparoscopic examination and concurred that the opinion of respondent that the lesion being extensive conservation surgery was not possible and the problem could effectively be addressed only by more extensive surgery that is removal of the uterus and ovaries. She also stated that the presence of chocolate cyst was indicative of endometriosis. She also stated that medication merely suppresses endometriosis and the definitive treatment was surgical removal of the uterus and both the ovaries. She also stated that hysterectomy is done when uterus comes out from a prolapse and the woman is elderly, or when there is a cancer of the uterus, or when there are massive fibroids or when a severe grade of endometriosis along with

ovaries or in cases of malignancy or the cancer of the ovaries.

52. The evidence therefore demonstrates that on laparoscopic examination, respondent was satisfied that appellant was suffering from endometriosis. The evidence also demonstrates that there is more than one way of treating endometriosis. While one view favours conservative treatment with hysterectomy as a last resort, the other favours hysterectomy as a complete and immediate cure. The age of the patient, the stage of endometriosis among others will be determining factors for choosing the method of treatment. The very suggestion made by appellant's counsel to the expert witness Dr. Sudha Salhan that worldwide studies show that most hysterectomies are conducted unnecessarily by Gynecologists demonstrates that it is considered as a favoured treatment procedure among medical fraternity, offering a permanent cure. Therefore respondent cannot be held to be negligent, merely because she chose to perform radical surgery in preference to conservative treatment. This finding however has no bearing on the issue of consent which has been held against the respondent. The correctness or appropriateness of the treatment procedure, does not make the treatment legal, in the absence of consent for the treatment.

53. It is true that the appellant has disputed the respondent's finding that she was suffering from endometriosis. The histopathology report also does not diagnose any endometriosis. The expert witness examined on behalf of the appellant has also stated that there was no evidence that the appellant was suffering from endometriosis. On the other hand the respondent has relied on some observations of the histopathology report and on her own observations which has been recorded in the case summary to conclude that the appellant was suffering from endometriosis. The evidence shows that the respondent having found evidence of endometriosis, proceeded on the basis that removal of uterus and ovaries was beneficial to the health of the appellant having regard to the age of the appellant and condition of the appellant to provide a permanent cure to her ailment, though not authorized to do so. On a overall consideration of the evidence, we are not prepared to accept the claim of appellant that the respondent falsely invented a case that the appellant was suffering from endometriosis to cover up some negligence on her part in conducting the diagnostic/operative laparoscopy or to explain the unauthorized and unwarranted removal of uterus and ovaries.

Re : Question No.(vi) :

54. In view of our finding that there was no consent by the appellant for performing hysterectomy and salpingo-oopherectomy, performance of such surgery was an unauthorized invasion and interference with appellant's body which amounted to a tortious act of assault and battery and therefore a deficiency in service. But as noticed above, there are several mitigating circumstances. The respondent did it in the interest of the appellant. As the appellant was already 44 years old and was having serious menstrual problems, the respondent thought that by surgical removal of uterus and ovaries she was providing permanent relief. It is also possible that the respondent thought that the appellant may approve the additional surgical procedure when she regained consciousness and the consent by appellant's mother gave her authority. This is a case of respondent acting in excess of consent but in good faith and for the benefit of the appellant. Though the appellant has alleged that she had to undergo Hormone Therapy, no other serious repercussions is made out as a result of the removal. The appellant was already fast approaching the age of menopause and in all probability required such Hormone Therapy. Even assuming that AH-BSO surgery was not immediately required, there was a reasonable certainty that she would have ultimately required the said treatment for a complete cure. On the facts and circumstances, we consider that interests of justice would be served if the respondent is denied the entire fee charged for the surgery and in addition, directed to pay Rs.25,000 as compensation for the unauthorized AH-BSO surgery to

the appellant.

55. We accordingly allow this appeal and set aside the order of the Commission and allow the appellant's claim in part. If the respondent has already received the bill amount or any part thereof from the appellant (either by executing the decree said to have been obtained by her or otherwise), the respondent shall refund the same to the appellant with interest at the rate of 10% per annum from the date of payment till the date of re-payment. The Respondent shall pay to the appellant a sum of Rs.25,000/- as compensation with interest thereon at the rate of 10% per annum from 19.11.2003 (the date of the order of Commission) till date of payment. The appellant will also be entitled to costs of Rs.5,000 from the respondent.