Jus Corpus Law Journal

Open Access Law Journal – Copyright © 2023 – ISSN 2582-7820
Editor-in-Chief – Prof. (Dr.) Rishikesh Dave; Publisher – Ayush Pandey

This is an Open Access article distributed under the terms of the Creative Commons Attribution-Non-Commercial-Share Alike 4.0 International (CC-BY-NC-SA 4.0) License, which permits unrestricted non-commercial use, distribution, and reproduction in any medium provided the original work is properly cited.

Case Comment: Samira Kohli vs Prabha Manchanda

Kashish[a]

[a]Government Law College, Mumbai, India

Received 10 January 2023; *Accepted* 25 January 2023; *Published* 30 January 2023

CASE BACKGROUND

An unmarried 44-year-old Samira Kohli, the appellant, complained of heavy menstrual flow. She alerted Dr. Prabha (the respondent) that she was still bleeding throughout her period and that it had been going on for nine days. Then she went for a laparoscopic test under general anaesthesia. The appellant went to the clinic as instructed on October 5, 1995, to take the test. On May 9, 1995, 44-year-old Samira Kohli met with Dr. Manchanda to complain about her ongoing monthly bleeding. She gave in and signed the consent form for admittance to the emergency room, medical care, and other procedures. She was subjected to a laparoscopic examination while under heavy anaesthesia. While Samira was unconscious and undergoing evaluation, Dr. Lata, and Ms. Manchanda & assistant doctor left the activity theatre and obtained the patient's & mother's consent for a hysterectomy because Samira Kohli was unconscious.

The laparoscopic examination was then performed on the appellant while she was under general anaesthesia. According to the respondent, the appellant had endometriosis. Suma Kohli, the appellant & mother, gave her permission for Dr. Lata Rangan, the respondent & assistant, to execute a general anaesthetic-assisted hysterectomy and a bilateral salpingo-oophorectomy

while the appellant was unconscious. The appellant walked out of the clinic unpaid on May 15, 1995. The respondent then filed a police complaint, saying that on May 15, 1995, Commander Zutshi, a friend of the appellant, had visited the clinic, verbally harassed and intimidated the respondent, and obtained the appellant's discharge without paying the bill.

On January 19, 1996, the appellant brought a claim for compensation of Rs. 25 lakhs with the National Consumer Disputes Redressal Commission, alleging that the respondent had treated her negligently and had conducted bilateral salpingo-oophorectomy and a hysterectomy without her permission.

ISSUES RAISED

- Is real/informed consent required for surgical treatments like bilateral salpingo-oophorectomy and abdominal hysterectomy?
- Did Samira Kohli give Dr. Manchanda permission to operate on her?
- Whether the principle of necessity allows for surgical procedures like bilateral salpingo-oophorectomy and abdominal hysterectomy to be carried out without the patient's consent.
- Is Dr. Manchanda accountable for damages to Samira Kohli because of any additional torts, such as assault and battery or negligence?
- Whether Dr. Prabha's actions constitute a defect in service.

INFORMED CONSENT

The emphasis on right and wrong human behaviour demonstrates the interconnectedness of law and ethics. Although they are intertwined, their capacity to uphold moral behaviour varies. As a result, the legal agreement serves as a declaration of ethical societal consensus. "Informed consent" is one of the problems that the doctor-patient interaction in both medicine and law faces. Since the Nuremberg trials, as well as other cases of human experimentation, this subject has been at the vanguard of biomedical ethics. The idea of "informed consent" was advanced by its proponents in a variety of ways, from the participatory decision to an individual's autonomous assent to endure medical interventions or take part in the research. This topic,

borrowed from clinical ethics, has been at the forefront of biomedical ethics since the Nuremberg tribunal and other instances of human experimentation.

The concept of "informed consent" was promoted by its proponents in several ways, including the participation choice and an individual's independent assent to experience medical interventions or participate in the research. American law is where the informed consent principle first appeared, along with a focus on personal freedom. It was initially established as a legal theory in the US in 1971 in the matter of Canterbury v Spence[1]. The independence of the patient was therefore highlighted in this case, allowing the practitioner to fulfill a duty by imparting knowledge to the patient. Respect for a person's dignity is the foundation of appropriate informed consent. To grant informed consent, the subject must be able to reason clearly and have access to all necessary information. Simple emotional or intellectual immaturity, high-stress conditions like post-traumatic stress disorder (PTSD) or severe cognitive disability, psychological disorder, substance abuse, extreme sleep deprivation, Alzheimer's disease, or being in a coma are examples of cognitive and judgmental impairments that can prevent informed consent. Getting informed consent isn't always required.

When a person is considered unable to make a rational decision, another person is typically allowed to do so on his behalf, such as the parent(s), legal guardian(s), or conservator(s) caring for a mentally ill person. In a clinical trial for medical research, these situations are anticipated and prevented by an ethical commission or institutional monitoring board. For a person to provide legally binding informed consent, disclosure, capacity, and voluntariness must all be present. The term "capacity" describes the subject's capacity to take into account the information provided and develop an informed judgment based on the potential effects of his or her choice. The term "voluntarism" refers to the subject's freedom to make decisions without intervention from outside forces like compulsion, deception, or undue influence.

It can be challenging to determine if informed approval is obtained because neither the expression of consent nor the acknowledgement of consequences entails that agreement has

[1] *Canterbury v Spence* 464 F 2d 772 (DC Cir 1972)

been given. Even if the subject protests that he understands and wants to give consent, it may not always be possible legally. Regardless of real permission, the rule in formal or medical situations is tacit permission by signing, which is typically legally relied upon. This is true for some procedures, such as those covered by a patient's pre-illness "do not resuscitate" order. The legal protection of two interests, security management as protected by laws against unwanted bodily contact and personal well-being as protected by laws governing professional competence, has led to the recognition of autonomy as a legally protectable interest. These interests, which represent the patient autonomy principle, can be summed up as physical autonomy and individual autonomy. The current interpretation of the notion of informed consent states that doctors must adequately tell patients about the costs, advantages, and other aspects of their care, as well as their legal right to refuse treatment.

How much information must be disclosed to the patient?

A patient should be able to weigh the pros and cons of accepting a particular treatment based on the accurate knowledge that the doctor must supply. This implies that a doctor should disclose the treatment's main components, its approach, as well as its goals, advantages, and drawbacks. If the intended rejection of consultation carries a large risk and has unfavourable impacts, it should also contain alternatives. However, there is no need to elaborate on the distant or hypothetical risks that can frighten the patient into forgoing treatment, choosing extravagant or wasteful alternatives, or increasing the patient's psychological stress. The patient's physical and mental health must be taken into consideration. In Samira Kohli's case[2], the Supreme Court made a deliberate decision to favour the idea of true consent while taking into account the actual medical and healthcare practices in India.[3]

Can a diagnosis's permission to perform further surgical treatments be extended?

By the Samira Kohli ruling, no more therapy may be given beyond what has already been disclosed to the patient even though the new procedure results in financial savings and patient

[2] *Samira Kohli v Prabha Manchanda* (2008) 2 SCC 1
[3] *Ibid*

discomfort reduction. Any additional behaviour is an attack and a lack of performance. The judgment only permitted life-threatening situations. Similar to how applying artificial dura results in the infusion of foreign substances into the human body, undertaking corporative procedures that involve the placement of iliac crest bone grafts or G bones is another method that warrants altering the required consent.

If a patient needs a craniotomy but is being examined for an aneurysm, the family cannot be contacted unless the patient's life is in danger. The unintended removal of a portion of the brain (lobectomy) may require extra surgery to be performed during the procedure. There are several unknown reasons why the court approves extra surgery in life-threatening situations or to ensure the patient's safety. Therefore, we will use our common sense to grasp our legal obligations through more than safe practice. Therefore, we will use our common sense to grasp our legal obligations through more than safe practice.

Who should seek permission?

A passing mention of this dimension was made in the ruling in the case of Samira Kohli. Although it provided no direction in this regard, it nonetheless left us with further ambiguity. Having the principle on your side is crucial. Getting the consent is done by a house surgeon, an intern, or even a resident (postgraduate). Are all of these employees qualified and trained to give their informed, genuine permission after discussing all necessary factors?

Who should seek permission for the medical service?

A passing mention of this dimension was made in the ruling in the case of Samira Kohli. Although it provided no direction in this regard, it nonetheless left us with further ambiguity. Having the principle on your side is crucial. To what extent an untrained individual can explain everything and help the patient comprehend all the important facts of the surgery? Getting the consent is done by a house surgeon, an intern, or even a residency (postgraduate). Are all of these employees qualified and trained to give their informed, genuine permission after discussing all necessary factors while the function is being performed?

What part does the witness play?

In the Samira Kohli case, the Supreme Court avoided addressing this issue. In numerous instances, the patient either claimed to sign something under duress from the doctor while underlining that they didn't completely grasp the content or suspected a fabrication. approval from two or more people. It is better to have two, one from the sufferer and one from a partner, parent, or close relative.

STANDARD OF CARE AND MEDICAL NEGLIGENCE: BASIC CHARACTERISTICS

It's crucial to appreciate the extent of the duty placed on a doctor or other medical professional to comprehend the breadth of carelessness. A doctor or other medical professional has a duty of care when deciding whether or not to take on a case, when determining what treatment to administer when administering that treatment, and when deciding not to take on any procedure outside of their scope of practice. It is anticipated that the physician will deliver a reasonable degree of competence and will practice a reasonable level of care.

Simply explained, negligence is a violation of a duty of care that causes harm or property damage. To establish negligence, there must be a "direct" or "proximate" causal link between the act of negligence and the harm that resulted. It is crucial to remember that now the test is; one, meaning that the causal link may be either direct or remote causation, and negligence may be blamed in either situation. For instance, in a case where a patient with approximately 50% burns passed away 40 days after receiving the incorrect blood type, despite receiving significant care after the error was discovered, the conclusion of misdiagnosis could not be avoided due to the close causal relationship between the wrong blood type fluid resuscitation and the patient's death.

The line separating civil accountability from criminal liability is hazy, and the Supreme Court hasn't yet developed any sufficiently sound standards offering any precise and understandable guidance. In Dr. Suresh Gupta v Govt. of NCT Delhi[4], the Supreme Court raised the bar for

[4] *Dr Suresh Gupta v Govt of NCT Delhi* (2004) 6 SCC 422

criminal accountability and demanded that medical malpractice be gross or reckless. It was found that merely failing to exercise the appropriate caution, diligence, or competence was inadequate to constitute criminal negligence. The prosecution under Section 304A IPC[5] was quashed by the Supreme Court, overturning the order of the High Court that had declined to quash the prosecution.

The validity of the Supreme Court's position was subsequently questioned because the word "gross" is missing from Section 304A IPC[6] and various principles cannot be imposed for actions resulting from medical professionals' carelessness and other types of negligence. As a result, the case was brought for review. The approach of a high degree of negligence being the requirement for enforcing criminal liability as adopted in Dr. Suresh Gupta was endorsed by a three-judge bench in ***Jacob Mathew v the State of Punjab***[7] on reconsideration. It was noted that to hold the existence of criminal recklessness or criminal negligence, it shall have to be found that the impetuosity was of such a degree as to amount to taking a potential danger. The oxygen cylinder that was connected to the body of the patient, in this case, was empty, and the elderly cancer patient was having breathing problems. Before a substitute could be made, the patient died. The doctors could not be prosecuted for a crime, according to the Supreme Court, which reversed the High Court's decision. The opinions of medical specialists are frequently requested from both sides when dealing with medical malpractice claims.

According to Section 45 of the Indian Evidence Act 1872[8], when a court must make an opinion on a scientific issue, the viewpoint of a person particularly knowledgeable in that field is relevant. It should be highlighted that a relevant view does not necessarily equate to a conclusive one. The expert's primary job is to present the court with all relevant information and the justifications for his conclusions so that the judge, which is not an expert, may make an informed decision. Therefore, even while the judges do not replace their opinions with those of experts,

[5] Indian Penal Code 1860, s 304A
[6] *Ibid*
[7] *Jacob Mathew v the State of Punjab* (2005) 6 SCC 1
[8] Indian Evidence Act 1872, s 45

they would have the authority to declare medical negligence if they found that the relevant medical professional's course of action was implausible or very unreasonable.

CONCLUSION

In the Samira Kohli case, the Bolam test was employed, and performance ethics were taken into account while defining actual or genuine permission and the calibre of information disclosure. When we compare the cases of Canterbury, Bolam, Sidaway, and Montgomery, we can see that the risk disclosure requirement and the doctor's obligation; to disclose private information distinguished each case's approach to consent. The patient's right to information was highlighted in the cases of Canterbury and Montgomery. The Bolam test was applied in the Samira Kohli case, and performing ethics were taken into consideration when determining what constitutes actual or genuine authorization and the quality of information disclosure. Few would argue that delinquency needs to be dealt with harshly in the field of medicine, just like it does in any other profession. It's not hard to figure out the causes. The only issue is determining the parameters of delinquency that could result in negative legal repercussions.

The treatment's outcome is essentially irrelevant because there are so many unknowns in medical practice. We can observe that the "risk disclosure" requirement and the doctor's duty to disclose personal information characterised each case's approach to consent when we contrast the cases of Canterbury, Bolam, Sidaway, and Montgomery. Because of Samira Kohli, assent was seen as a legal tool for demonstrating the inadequacy of the assistance provided. Assent also helped doctors determine whether a patient was being honest when they expressed their judgment under threatening behaviour. However, the court gives instructions for the disclosure of "sufficient material" and the decision to use the Bolam test, which is used to prove medical negligence. Accordingly, this case study demonstrates how the authentic or genuine consent method served as a tool to guarantee the patient's real nobility and real prosperity. The instances of Canterbury and Montgomery emphasised the patient's entitlement to information.

In the Samira Kohli case, performing ethics were taken into account when assessing what defines actual or genuine permission and the calibre of information sharing. The Bolam test was

used to make these determinations. The court justified its position, noting that this decision upholds the government assistance state standard enshrined in Art. 21 of the Indian Constitution[9], as well as the requirement for including informed consent under Section 13 of the Indian Contract Act.[10] The Canterbury and Montgomery cases highlighted the patient's right to information. The value of the patients' decisions should be taken into account while making clinical judgments. By providing the necessary International Journal of Integrated Law Review, the Samira Kohli case regulations on the information exposure criterion have been addressed.

The evaluation of the patient's propensity has been avoided in the execution of the expert disclosure norm, according to the International Journal of Integrated Law Review. Given the analysis of this case and the various legal disputes mentioned, we are unable to deny patients the right to obtain information on social and financial grounds, as was done in the case of Samira Kohli, because the "obligation" to disclose information should be clear from clinical norms, custom, and practice. When patients' choices are highlighted, and the responsibility of the doctor to disclose information is emphasised, the patients' independence is taken into consideration. The requirements are reasonable, and accountability is strengthened because no one can escape inspection as a result of tightening liability in some situations. In this regard, the law zealously protects the independence of medical.

Nevertheless, the law also aims to defend and safeguard a patient's interests to expect a basic degree of treatment. For the patient to process the information and make morally right decisions, the physician has a legal and ethical obligation to provide the patient with adequate information. Judges do not want to force their wisdom on medical practitioners, and neither does the law attempt to make any needless inroads into their domain. The criteria used to determine the minimum standard are also greatly influenced by the body of knowledge that was available at the relevant time and by the pervasive medical practices and opinions.

---

[9] Constitution of India 1950, art 21
[10] Indian Contract Act 1872, s 13