

Guardianship for Incapacitated Persons in Medical Interventions: Legal and Ethical Considerations from the Indian Perspective

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Abstract

Any medical intervention, even if for the benefit of a patient, requires the respect for patient autonomy and therefore, consent of the patient has to be taken by the medical practitioner before treating a patient. It is an established norm that the respect for autonomy cannot be discarded in the case of incapacitated persons. Therefore, the guardians play an important role in deciding about the medical interventions for incapacitated patients. The process of obtaining consent from guardians of incapacitated persons is not easy, especially in light of difficulties involved in determining the guardian as well as in testing the genuineness of a decision made by him or her on behalf of the incapacitated patient. In addition, such a scenario also brings forward several ethical and legal concerns to medical practitioners and guardians. Hence, the present day challenge in the treatment of incapacitated persons is found in terms of dealing with ethico-legal concerns in giving consent for medical interventions with a view to uphold the best interest of the incapacitated persons.

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I. Introduction

Treatment of incapacitated persons poses tremendous challenge to the medical fraternity due to the manifold legal issues associated with it. Since the incapacitated persons are not in a position to provide informed consent, which is the essence of medical interventions across the globe, the medical practitioners or the hospital authorities have the task of

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obtaining the consent of the incapacitated patient's legal guardian. This is not an easy task in the cases wherein several persons, closely related to or associated with the incapacitated patient, come forward to establish themselves as guardians, and express contrary views on the treatment of the patient. Even if the problems are not encountered in zeroing down the legal guardian of an incapacitated patient, the medical practitioners would be in a fix as to the genuineness of consent given by the legal guardian. This is more so in case of physician assisted suicide or withdrawal of life support system of an incapacitated patient. Due to the inherent limitations in testing the veracity of consent given on behalf of the incapacitated patient, medical practitioners would have difficulties in arriving at a wise decision. It is to be noted that while their decisions to act on the consent given on behalf of the incapacitated patient might go against the interest of the patient, their failure to act on it may subject them to the burden of bearing the cost of treatment, which the guardian of the patient may refuse to pay. This is why the Indian Supreme Court in the historic judgment of *Aruna Ramachandra Shanbaug v. Union of India and Others*¹ observes that the decision to withdraw life support can only be done with approval of the concerned High Court, which should act as *parens patriae* to protect the best interests of the patients.

While above are the concerns of the medical fraternity, the legal guardians of the incapacitated patient also find difficulties in certain decision-making. On the one hand, it is difficult for them to see the sufferings of the patient, and on the other hand, they would not be willing to give consent for the termination of life of their dear one. The economic factors, ranging from the guardian's capability to bear the expenses of treatment to the benefits gained by the guardian out of any decision, may play a key role in arriving at a conclusion by the guardian, which may be detrimental to the interests of the incapacitated patient. Thus, all these factors open up a Pandora's Box of determining good faith of the guardian in decision-making. Similar problems at the guardians' level may also arise with respect to giving consent for medical experimentations or surgical interventions, which may be risky but inevitable as a last ray of hope for recovery of the incapacitated patient. In the wake of these ethico-legal dilemmas, the present paper first probes into the requirement of consent in medical interventions, and the determination of guardianship to obtain such consent on behalf of incapacitated patients. In the second part, difficulties faced by the medical practitioners and hospital authorities in relying on the consent of the guardian are examined. The third part highlights the guardian's dilemma in various instances while taking a decision on medical intervention for incapacitated patient. Finally, the paper concludes with few suggestions to address these issues.

¹ 4 SCC 454 (2011).

II. Consent in Medical Interventions

'Consent' has acquired a very important position in the healthcare sector world over. Its French equivalent '*consentir*' means 'to agree' or 'concur' and its Latin equivalent '*consentire*' implies to 'feel together'. Taking of consent from the patient before commencing any treatment is the *sine qua non* of medical practice. Seen from the perspective of a patient, giving or withholding consent for any medical treatment or intervention is a right that has been bestowed upon him by law, which if avoided, could give rise to far reaching legal consequences for the medical practitioner under civil or criminal law. This is one of the primary reasons behind 'consent' assuming enormous significance in the present times. While on the face of it, taking consent for medical treatment may seem to be an uncomplicated and simple process, in reality, it includes a number of complex questions that need to be adequately addressed to avoid legal action. Medical practitioners always find difficulty in following appropriate procedure for obtaining consent,² and more particularly, in case of incapacitated patients, finding the right person to give valid consent on their behalf is a herculean task.

The requirement of taking consent from a patient stems from one's basic legal and ethical right of self-autonomy. The right of autonomy, often described as the "right of self-determination, the right to privacy, liberty and the right to be let alone" empowers a patient who is competent in the eyes of law by bestowing upon him the legal right to accept or decline the treatment offered by a doctor. Hence, it is completely within the domain of a patient to decide his best interests, and accordingly, take a decision.³ *Schloendorff v. Society of New York Hospital*⁴ stands as the first case to give legal recognition to the patient's autonomy, which went on to establish a legally competent adult's right to refuse medical treatment. While delivering judgement, Benjamin Cardozo J. observed that every adult of sound mind has the privilege to decide what shall be done to his body.

Respect for patient's autonomy and requirement of consent became cornerstone of ethical medical practices in the aftermath of Nuremberg Trials. The trials brought to light the brutality of the medical experiments that were carried out by Nazi doctors in the guise of scientific research, which necessitated the laying down of ten basic principles in the form of Nuremberg Code 1947. The Code made it mandatory to acquire voluntary and informed consent from human subjects.⁵ This was followed by another set of principles, the Ethical Principles for Medical Research Involving Human Subjects, popularly known as the Helinski

² Jane Lynch, *Consent to Treatment* (Cornwall: Radcliffe Publishing Ltd., 2011), 1.

³ Omprakash V. Nandimath, "Consent and medical treatment: The legal paradigm in India," *Indian Journal of Urology* 25, no. 3 (2009): 343.

⁴ 211 N.Y. 125; 105 N.E. 92 (1914).

⁵ K. Kannan, *Medicine and Law* (New Delhi: Oxford University Press, 2014), 58.

Declaration, adopted by the 18th General Assembly of the World Medical Association. The Declaration of Helinski as amended in October 2013⁶ contains detailed provisions on informed consent and specifically lays down that no individual who is competent to give informed consent shall be made a subject of medical research unless he or she freely consents to it.⁷

It is interesting to note that the notion of “consent” has transformed into “informed consent” in the medical jurisprudence over the years. Justice Cardozo, in the 1957 medical malpractice suit of *Salgo v. Leland Stanford Jr. University Board of Trustees*⁸, articulated the words ‘informed consent’ for the first time. In this case the plaintiff, who became paraplegic following a procedure of aortography, which was intended to locate a block in his abdominal aorta, alleged that his physician had not disclosed to him the potential risks of the procedure before he was made to undergo the same. The Court ruled that it was the duty of the physician to disclose to the patient “all the facts which mutually affect his rights and interests and of the surgical risk, hazard and danger, if any.” Any fact that a physician withholds, which in turn incapacitates the patient to give an intelligent and sound consent to the proposed treatment, makes the physician liable for non-disclosure.⁹

III. Legal Consequences of Absence of Consent

Obtaining a valid consent from the patient is a must for any medical treatment to be lawful, since treatment without consent may result in an action under tort law and criminal law. Under English Law, any person who intentionally touches another without consent or without lawful authority may be proceeded against under the tort of battery. On similar lines any medical treatment or procedure that involves contact may be carried out only if valid consent has been obtained from the patient or any other person authorized by law to consent on his behalf, or if law permits such physical contact irrespective of consent.¹⁰ In the United States of America, besides unpermitted touching, an action in battery may be brought if a patient who is incapable of giving valid consent is treated, or when the physician oversteps the boundaries of the consent that has been obtained from the patient without adequate reason or justification, or when the patient is treated by a physician who

⁶ By the 64th WMA General Assembly held in Fortaleza, Brazil in October 2013.

⁷ “WMA Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects,” <http://www.wma.net/en/30publications/10policies/b3/>.

⁸ 154 Cal.App.2d 560 (1957).

⁹ *Ibid*.

¹⁰ David Lock, “Consent to Treatment: The Competent Patient,” in *Principles of Medical Law*, eds. Andrew Grub, Judith Laing, and Jean McHale, 3rd ed. (New York: Oxford University Press, 2010), 439-41.

has not been authorized. A claim for the tort of battery can be raised even if the medical treatment is “well-intentioned, non-negligent and does not cause physical harm” since battery comes under the class of intentional tort.¹¹

In India, the lack of informed consent to medical treatment, if brought up before a court of law, is treated as negligence on the part of the doctor. However, according to some authorities, an action in battery may be brought in place of an action in negligence if – (i) a patient consents to a treatment without understanding the basic nature and purpose of the treatment, (ii) a procedure other than the procedure that has been consented to is performed, (iii) a particular procedure is specifically refused by a patient but it is still performed, or (iv) a conditional consent is given by the patient and the treatment given to the patient does not satisfy the condition.¹² Moreover, the criminal law provisions relating to assault and battery may also be attracted in certain circumstances wherein the doctor touches the patient or subjects the patient to medical investigations without consent.¹³

The jurisprudential development on the requirement of informed consent is incorporated in India especially after the enactment of Consumer Protection Act 1986. Though there was an initial scepticism as to the application of the Act to medical services, the celebrated decision of the Indian Supreme Court, *Indian Medical Association v. V. P. Shantha and Others*¹⁴, has brought the medical profession within the domain of the Consumer Protection Act. Now, under Section 2(1)(g) of the Act, failure to take informed consent is considered to be deficiency in medical services. Hence, the consumers of such services can proceed against concerned doctors and hospitals under the Consumer Protection Act for deficiency of service.

In addition, the failure of the doctor to obtain consent from the patient also amounts to professional misconduct under Chapter 7 of Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations 2002. The medical practitioner may be subject to punishment and disciplinary action under Chapter 8 of the 2002 Regulations for such misconduct. Hence, in India, legal consequences of treating a patient without consent would be far-reaching; the medical practitioner may be subject to action under tort law or consumer protection law for medical negligence, criminal law for assault or battery, and 2002 Regulations for professional misconduct.

¹¹ Christopher White, Arnold J. Rosoff and Theodore LeBlang, “Informed Consent to Medical and Surgical Treatment,” in *Legal Medicine*, ed. Shafeek S. Sanbar, 7th ed. (Philadelphia: Mosby Elsevier, 2008), 337.

¹² Tapas Kumar Koley, *Medical Negligence and Law in India, Duties, Responsibilities and Rights*, 3rd ed. (New Delhi: Oxford University Press, 2014), 114-15.

¹³ Nandimath, *supra* note 3.

¹⁴ SCC (6) 651 (1995).

IV. Consent for Incapacitated Patients and Guardianship

Given the far-reaching consequences of not obtaining consent, medical practitioners need to obtain prior informed consent in all medical interventions to avoid any litigation. Such consent in the usual circumstances has to be obtained from the concerned patient undergoing treatment who is “competent” and has “capacity” to give valid consent. Competence may be defined as the ability of an individual to comprehend the information about the medical treatment that has been imparted by the doctor, to appreciate the implications of the same, to assess the information, to choose or decline the line of treatment suggested and to articulate a response. The competence of a person is not static but changes over the time and varies from one decision to another. While a child may not be competent to give consent to medical treatment owing to his age, he would become competent once he attains adulthood. It is in this context that the term “competence” has a legal connotation and is primarily determined by the courts of law.¹⁵

On the other hand the term “capacity” is argued to be a medical term, which is looked into by doctors before determining a patient’s ability to make independent choice.¹⁶ For example, a person who is mentally or physically unwell may be incapacitated for a short duration to make decisions that are in his best interest concerning his health. The determination of the fact that at what point of time such a person is incapacitated, and when he regains capacity, has to be subject to medical determination. Therefore, the courts often call upon the services of medical professionals to give their expert opinions in deciding the capacity of persons to comprehend facts and make independent decisions. It is nevertheless pertinent to mention that the distinction between competence and capacity is rarely looked into in practice.¹⁷ Therefore, this paper covers both of them within its ambit of coverage.

The right of self determination and bodily integrity would preclude any individual to consent in place of a competent adult directing a physician as to what should be done to his body. However, this norm is applicable only when the patient is competent and has capacity to take decisions in his best interest. Thus, it is not always that consent to a medical procedure is obtained from the person undergoing treatment.¹⁸ In simple terms, there would be a requirement of taking the consent of a person competent to give consent

¹⁵ Raphael J. Leo, “Competency and Capacity to make Treatment Decisions: A Primer for Primary Care Physicians,” *Primary Care Companion to the Journal of Clinical Psychiatry* 1, no. 5 (1999): 131.

¹⁶ *Ibid.* at 132; See also P. Lepping, “Consent in Psychiatry: An Ethical Review,” *Psychiatric Bulletin* 27 (2003): 285-89.

¹⁷ “Capacity and Competence,” <http://lifeinthefastlane.com/cc/capacity-and-competence/>.

¹⁸ Alasdair Maclean, *Autonomy, Informed Consent and Medical Law: A Relational Challenge* (New York: Cambridge University Press, 2009), 118.

legally on behalf of the patient, if the patient is incompetent or incapacitated, and therefore unable to give valid consent. This leads to a critical question: who can give consent on behalf of an incapacitated patient to carry out medical interventions?

Usually, the parents or the guardians are competent to give consent on behalf of the incapacitated patients. The term “guardian” refers to a person who has legal authority to care for the person or property of another. It may refer to a parent, spouse or close relative of the incapacitated patient in case of medical interventions. In cases of emergencies involving minors, the principle of *in loco parentis* applies, which means in place of parents. Thus, if a minor needs emergency medical care and the parents or guardians are not available, consent for the treatment may be taken from any person in charge of the child. If there is any doubt as to the competency of the patient, the incompetence of the patient as suspected by the physician must be substantiated by a judicial determination. In the case of such patients, it is advisable to obtain a judicial declaration that declares the mental incompetence of the patient and either authorizes the medical practitioner to treat the patient or provides for the appointment of a guardian who can take decisions on behalf of the patient for medical interventions.¹⁹

In the absence of a parent or guardian, the Indian judiciary has stressed on the requirement of consent from the “next friend” of the incapacitated patient for any medical intervention. The determination of “next friend” is dependent on the facts of the case, and involves several complications especially in light of the requirement of upholding the best interests of the incapacitated patient. Hence, the medical practitioners would not be the right persons to venture into this legal determination.

The question of determination of “next friend” has been addressed by the Indian Supreme Court in *Aruna Ramachandra Shanbaug v. Union of India and Others*²⁰. In this case, Aruna Shanbaug, while working as a nurse in KEM Hospital, Mumbai, had been sodomized by a sweeper, who in order to restrain her movement had tied a dog chain around her neck. This had damaged her brain and had reduced her to persistent vegetative state in which she had survived as a virtually dead person for thirty seven years. In the absence of support from family members, she was under the treatment and care of doctors and staff of KEM Hospital, Mumbai. Ms. Pinki Virani, a social activist and the petitioner in this case, had visited Aruna Shanbaug on many occasions and had written a book on her. According to the petitioner, the condition of Aruna Shanbaug is sub-human and there is no scope for recovery (as testified by the doctors treating her). Hence, the petitioner prayed the Court to allow the withdrawal of life support of Aruna Shanbaug to bring her a peaceful death.

¹⁹ *Supra* note 12, p. 116.

²⁰ 4 SCC 454 (2011), *supra* note 1.

Since this case involved a determination on involuntary passive euthanasia wherein the patient is not in a position to give consent, the Court first looked into the preliminary question of standing to bring the claim on behalf of the patient before addressing the merits of the case. This necessarily involved the determination on the question – who is competent to give consent as “next friend” for the withdrawal of life support on behalf of the incapacitated patient, Aruna Shanbaug? The Supreme Court of India found that the “next friend” of the patient in the present case would be the KEM Hospital staffs, who have looked after the patient for thirty seven years and not the plaintiff, who has only visited the patient on few occasions and written a book on her.²¹ Since the KEM Hospital staff has opposed the move of the petitioner, the Court refused to authorize euthanasia.

The factual circumstances in *Aruna Shanbaug* did not involve too much of complications in the determination of ‘next friend’. However, the same cannot be expected in every case. Even in *Aruna Shanbaug*, if the facts were reverse, and the petition for euthanasia was filed by the KEM Hospital authorities and a social activist like Ms. Pinki Virani has opposed such a petition, Court’s determination of next friend would have become a much complicated affair especially in light of the Court’s obligation of considering and upholding the best interests of the patient.

V. Difficulties Faced by the Medical Practitioners in Proceeding with the Consent of Guardians

The historic equation of healer with that of God keeps the medical practitioners in an altogether unique position in society. The expectation of people from medical practitioners has always been high. They are expected to act only in the best interest of the patient, and without considering any extrinsic factors. Similarly, the “guardian” of any patient is supposed to act in the best interest of the patient as he is giving the consent in place of the consent of the patient himself/herself. However, in practical sense, we cannot rule out the possibility of guardians of incapacitated patients misusing their position for achieving some ulterior purposes. Thus, the determination of good faith of the consent giver for medical intervention on behalf of the incompetent patient becomes crucial. This opens up a Pandora’s Box of questions like, who determines good faith? What are the factors to be considered in such determination? What procedure needs to be followed? The issue would become more complicated in the instances where a patient does not have parents or family members, and the consent for medical intervention is supposed to be given by a person

²¹ *Ibid*, para 126.

calling himself/herself as the “next friend” of the patient. Such instances, as discussed above²², would not only involve the determination of questions relating to “good faith” but also the primary question of who is the “next friend” of the patient?

In light of the above factors, simply proceeding with the consent of the guardian/next friend of incapacitated patient would become difficult for the medical practitioner. He, being a person without adequate competence to decide on the validity of consent in such cases, would face a dilemma in making a wise decision. In addition, while his decision to act on the proxy consent given on behalf of the patient might go against the interest of the patient, his failure to act on it may put him under the burden of incurring the cost of treatment, which may be refused to be paid by the guardians of the patient. Though the resort to the judiciary is an available option, it would cause undue hardship on the medical practitioner. Thus, there is every scope for the medical practitioners being forced to accept the willingness of the guardians of incapacitated patients.

There are also instances of patients and their guardians having conflicting views on medical interventions. Such instances further aggravate the dilemma of medical practitioners. One of the classic examples of such contradiction can be evidenced under the Indian Medical Termination of Pregnancy (MTP) Act 1971 as amended by the MTP (Amendment) Act 2002, which under Section 3(4)(a) lays down that the pregnancy of a woman, who has not attained the age of eighteen years, or who, having attained the age of eighteen years, is mentally-ill, shall be terminated only with the consent of her guardian in writing. This may result in conflicting opinions on termination of pregnancy between the incapacitated pregnant woman and her guardians.

In *Suchita Srivastava and Another v. Chandigarh Administration*,²³ a mentally retarded woman became pregnant as a result of alleged rape when she was the inmate of a government run welfare institution in Chandigarh. The Chandigarh Administration moved to the High Court of Punjab and Haryana to grant permission for the termination of the pregnancy. According to the petition, the pregnant woman was mentally retarded and also an orphan, and consequently, there was no one to take care of her or her prospective child in the future. There was also no guarantee that she would bear the child until birth and no prediction could be made regarding the childcare after its birth.

The High Court established an Expert Body consisting of medical experts and a judicial officer to make a thorough enquiry of the facts. The Expert Body found that the pregnant woman had expressed her willingness to continue the pregnancy, and it formed an opinion that the continuation of pregnancy would not create any serious injury to her physical health and the effect on her mental health was not predictable. Despite such an opinion

²² See *Aruna Ramachandra Shanbaug v. Union of India and Others* 4 SCC 454 (2011).

²³ (3) GLH 468 (2009).

in favour of the continuation of the pregnancy, the High Court ruled that the pregnancy could be terminated, since the victim was not in a position to understand the consequences of continuing the pregnancy and might not be capable of taking care of the child.

On appeal, the Supreme Court reversed the order of the High Court. It observed that the reproductive choice of the pregnant woman should be respected, irrespective of her lack of understanding of many aspects relating to pregnancy and birth of the child. It drew a delicate distinction between the “mental retardation” in the current case and “mental illness” stipulated under the MTP Act. This is also supplemented by the fact that the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act 1995 treats “mental retardation” and “mental illness” separately. Therefore, only in the case of “mental illness,” contemplated under the MTP Act, the consent of the guardian is required for the termination of pregnancy.

Similarly, in *V. Krishnan v. G. Rajan Alias Madipu Rajan*²⁴, the petitioner prayed for a direction to the Superintendent, Government Kasthuri Bahai Gandhi Hospital, Triplicane Madras, to terminate the pregnancy of his daughter Sasikala. He contended that his daughter became pregnant after she was kidnapped by the respondent under the pretext of marriage. According to petitioner, Sasikala was still a teenager and pregnancy at that tender age would lead to many complications physically, physiologically, mentally and socially. However, the pregnant girl refused to undergo the termination of pregnancy. In the absence of consent of the pregnant girl to abort, the Madras High Court rejected the petition and directed for several measures to be taken for providing necessary care and attention to the girl during and after the pregnancy period.

The problem in relying on the consent of guardians is further witnessed in the cases of euthanasia, since proceeding on consent of the guardian would result in the termination of life of the patient. The determination of genuineness of consent in such circumstances is more pertinent as it results in the irreversible condition of death. A medical practitioner, having no competence to take a call on this, would require judicial assistance for making a justifiable decision. This is why the Indian Supreme Court, in *Aruna Ramchandra Shanbaug v. Union of India and Others*,²⁵ has provided a detailed procedure along with the necessary judicial intervention for withdrawing the life support of any patient.

The Court clarified that whenever the decision to withdraw life support is made by the near relatives or doctors or next friend, approval has to be sought from the concerned High Court, which shall be empowered to give appropriate directives under Article 226 of the Constitution.²⁶ The procedure that the High Court has to follow once an application

²⁴ 1 Mad. L.W (Cri) 16 (1994).

²⁵ 4 SCC 454 (2011), *supra* note 1.

²⁶ *Ibid.*, para 126.

for the withdrawal of life support is made has also been laid down by the Supreme Court in the aforesaid judgement. The Supreme Court directed that the prescribed procedure summarized hereunder would be followed all over India until the Parliament devises legislation on this subject:²⁷

(a) On receipt of an application to withdraw life support, the Chief Justice of the High Court would have to immediately constitute a Bench of at least two Judges who would decide whether or not approval should be granted. In making this decision the Bench should seek the opinion of a committee of three reputed doctors to be nominated by the Bench, which should preferably consist of a neurologist, a psychiatrist, and a physician.

(b) The committee of doctors has to produce a report to the Bench, which shall be made after carefully examining the patient, consulting the record of the patient and taking the views of the hospital staff.

(c) The High Court after appointing the Committee shall simultaneously issue notice to the State and close relatives, for example, parents, spouse, brothers/sisters etc. of the patient, and in their absence his/her next friend, and supply a copy of the report of the doctors' committee to them as soon as it is available. After giving them a chance of hearing, the High Court Bench would give its verdict. In reaching its decision due weight and consideration would be given by the High Court to the views of the near relatives and committee of doctors.

(d) The decision of the High Court would have to be rendered speedily and with specific reasons in accordance with the principle of "best interest of the patient."

In addition to the above-mentioned difficulties faced by the medical practitioners in the specific instances like abortion and euthanasia, there are also difficulties faced by the medical practitioners in the wake of their overwhelming duty of saving the patient's life. While it is extremely pertinent to obtain consent before treatment either from the patient or from the guardian of incapacitated patient, it must also be borne in mind that the primary duty of a doctor is to save the life of his patient. Therefore, withholding treatment

²⁷ *Ibid.*, para 138 - 142.

from a patient in situations which may prove fatal for the patient due to non-availability of consent may also result in the doctor being held guilty of negligence.²⁸ This also means that doctors need to be extra cautious in dealing with the situations wherein the consent is given or withheld by the guardians on behalf of the incapacitated patients.

VI. Guardians' Dilemma in Giving Consent

Giving consent or withholding consent for medical interventions on behalf of the incapacitated patient is not an easy task for the guardians. The ethical dilemmas surrounding such decisions are many and vary from case to case. Since the consent for medical intervention, or alternatively, withholding such consent may risk the life and health of the incapacitated patient, the guardians are unsure as to which alternative is in the best interest of their loved ones (meaning, the patients concerned). Complications involved in consenting for involuntary passive euthanasia can best illustrate this dilemma. On the one hand, guardians of the incapacitated patient would find difficulty in seeing the suffering of the patient. Their ethical egoism may entice them to end the suffering, since they might conclude that the emotional trauma in seeing the patient's suffering is much greater than the death. On the other hand, they also find difficulty in giving consent to terminate the life of the patient. It is hard for them to digest the fact that they are in a way responsible for the death of their dear one. Moreover, the economic conditions of the family would also play a crucial role in decision-making, especially when the patient is in a persistent vegetative state and the family is not in a position to support the expenses involved in the treatment of the person. Thus, it is always difficult for the guardians to arrive at a decision on euthanasia.²⁹

In addition to this, the guardians' dilemma also resides in the societal reception of their judgment to give consent for euthanasia. The human tendency of being attracted by the economic considerations has created a stigma against those who consent for the termination of other's life. Irrespective of the fact that whether or not there is any economic consideration, the guardians would, therefore, be hesitant in permitting the termination of life, fearing societal reactions. The most frequent argument in the common parlance that there is always a hope for recovery from any sort of critical condition during the lifetime of the patient, though based on miracles, also adds on to the emotional trauma of the guardians, leading them to feel guilty of depriving this opportunity for their beloved person.³⁰

²⁸ Reference may be made to *Dr. T.T. Thomas v. Smt. Elisa and Others* AIR 1987 Ker 52.

²⁹ Sandeepa Bhat B., "Euthanasia in India – Is Ethics in the Way of Law?," in *Reflections on Medical Law and Ethics in India*, ed. Sandeepa Bhat B. (Kolkata: Eastern Law House, 2016), 141.

A similar dilemma of the guardians can also be seen in giving consent on behalf of incapacitated patients for surgical interventions. As the medical practitioners are unsure about the success rates of many surgical interventions, they leave it to the patients or the guardians of incapacitated patients to make a decision on surgery. This brings difficulties to the guardians as their decision to consent for surgery is subject to the risk of suffering and even immediate death of their beloved person. But again the denial of consent for such surgical intervention accords a guilty feeling to the guardians for their failure to make an attempt to cure the patient. Hence, stepping into the shoes of a guardian of an incapacitated patient in its true sense is a difficult task for every human being.

VII. Concluding Remarks

The concept of medical intervention has undergone transformation from the paternalistic doctor-patient relationship to patient autonomy model. One of the necessary corollaries of such transformation is the elevation of consent for medical intervention into a top-tier requirement. Treating the patient in the absence of consent is punishable in all jurisdictions. This norm is equally applicable even in the cases wherein the patients are incapacitated to give consent, which led to the requirement of finding a suitable person (guardian) to give consent on behalf of the incapacitated patient.

The guardian has a good faith obligation to act in the best interest of the incapacitated patient. Accordingly, the law first looks for parents, a spouse, or other close relatives of the incapacitated patient, who are intimately concerned with the well-being of the incapacitated patient, as guardians to act on his or her behalf. It is only in the absence of such persons that the Indian judiciary has gone in search of a “next friend” of the incapacitated patient to act as a guardian to give consent for medical interventions.

Though the guardian is supposed to act in the best interest of incapacitated patient, this does not absolve the medical practitioner from his duty of acting in the best interest of his patient. Hence, the medical practitioner cannot blindly rely on the consent of the guardian for medical intervention by abdicating his duties. There are instances wherein the guardians have tried to achieve their ulterior purposes by giving or withholding consent for medical interventions on behalf of incapacitated patient. Therefore, the medical practitioners need to be cautious enough in relying on such consent, and where necessary, should seek the assistance of the judiciary for arriving at a right decision.

The author believes that the most precarious problem in this subject area is faced by the well-meaning guardians of the incapacitated patient. They are supposed to decide on

³⁰ *Ibid.*

consent by acting just like the incapacitated patient himself/herself, which involves lot of subjectivity without any objective criteria to assess. They stand as helpless persons amidst an ethical quandary. Unlike the case of the medical practitioners, neither judiciary nor legislature would be of any help in sorting out the guardians' dilemma.

One of the possible steps to address the above concerns is to establish a three member committee in every hospital to assist the stakeholders in making appropriate decisions regarding medical interventions on behalf of the incapacitated patients. The proposed committee shall consist of a medical practitioner specialised in the area of treatment (but not the one who is actually treating the patient), a psychiatrist or a counsellor, and a lawyer. Unlike the courts of law or other quasi-judicial bodies, the committee shall not be involved in making decisions on behalf of the incapacitated patients, since such a process would not reflect the respect for patient autonomy. The committee shall be advisory in nature, and assist by giving necessary advice from ethical and legal perspectives to the medical practitioners treating the incapacitated patients as well as to the guardians of such patients. This innovative step would not only provide relief to the medical practitioners and guardians of incapacitated patients in discharging their burden of decision-making, but also protect the best interest of the incapacitated patients.

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