

# “DOES A PATIENT HAVE THE RIGHT TO REFUSE MEDICAL TREATMENT?”

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*“If I had my way, I could say good-bye, could choose my time and be calm and collected about it. I had a good life and I would dearly like a good death my last wish to die with dignity.”<sup>1</sup>*

*“Entry and exit are gate of human existence, just as a man need a midwife to aid him being born, he also needs similar means to be unborn-to die peacefully....”<sup>2</sup>*

## **Introduction**

In the annals of medical jurisprudence, the right to informed consent has occupied the central space. One of the most controversial issues in contemporary health care is whether and when a patient may refuse medical treatment, the likely consequence of which is death. The notion of patient’s absolute autonomy has been the subject of much debate in Indian legal circles.

This paper deals with the right to refuse medical treatment of the patient at a three-fold level. Firstly, it seeks to test the premise of the right to refuse medical treatment on the touchstone of various provisions of the Constitution. Secondly, it examines the right to refuse medical treatment against the parameters of criminal law. Thirdly, it inspects various defences available to the doctor in the law of torts. Alongside, it also deliberates on the jurisprudential basis of informed consent. At the outset it important to state that this article argues on the right to refuse medical treatment for a terminally ill patient<sup>3</sup> only.

## **(A) Formulating the Postulate of the Right to Refuse Medical Treatment**

### ***I. Does a Patient have Right to Privacy under the Article 21 of the Constitution?***

An individual has an innate right to privacy. To put it more plainly, the right to privacy is a domain into which nobody can intercede. The right to refuse medical

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1 See, Wolhandler, *Voluntary Euthanasia for the Terminally Ill and the Constitutional Right to Privacy*, 69 Cornell L. Rev. 363 (1984) at p. 374.

2 See, Deema Khatkate, *Whose Life is it any Way?*, EPW, August 1990 at 872.

3 A terminally ill patient for the purpose of this paper is one whose process of natural death has commenced on account of dreadful disease.

treatment stems from the patient's right to privacy.<sup>4</sup> The right to privacy has been widely acclaimed and recognised in nearly all jurisdictions.<sup>5</sup> In a catena of cases, the Supreme Court has interpreted the right to privacy to be an essential component of the Right to Life and Personal Liberty guaranteed under Article 21 of the Constitution.<sup>6</sup> The right to privacy lies under the penumbra of other enumerated rights, especially the right to liberty enshrined under Article 21<sup>7</sup>. The enjoyment of other rights is not possible without inherent right to privacy. It is submitted that the right to privacy encompasses patient's right to refuse medical treatment.<sup>8</sup> Competent patients have a right to make their own medical decision and treatment if they wish, even if it means the prospect of natural death.<sup>9</sup> In medical care cases, the presumption is that a competent individual has the freedom to make his own

4 See, Richard, *Liberalism, Public Morality and Constitutional Law: prolegomenon to the Constitutional Right to Privacy*, 50(1) *Law and Contemporary Problems* 123 (1988) at p. 148; Jed Rubienfield, *The Right to Privacy*, 102 *Harv. L. Rev.* 737 (1997) at p. 789; Prof. William L., *Privacy*, 48 *Calif. L. Rev.* 383 (1960) at p. 421; Thomas, *Thinking Clearly About Privacy*, 55 *Wash.L.Rev.* 777 (1980) at p. 794; Bishnu Prasad, *The Right to Privacy*, A.I.R.(J) 1991 at pp.113-121; Steven J. Wolhandler, *Voluntary Euthanasia for the Terminally Ill and the Constitutional Right to Privacy*, 69(2) *Cornell L. Rev.* 363 (1984) at p. 396, presents this argument:

"it is legally inconsistent to honour a terminal patient's request that life support equipment be removed, but to deny a similar situated patient's request for an immediate and painless end merely because a second party's active assistance is needed to implement the latter request. Prohibiting a second party from helping a patient commit self-euthanasia by imposing legal sanctions on the party is effectively equivalent to denying the patient the right to make that decision in the first place."

5 Article 17 of the International Covenant on the Civil and Political Rights, 1966 and Article 12 of the Universal Declaration of the Human Rights, 1948.

6 *Krak Singh v. State of U.P.*, (1964) 1 S.C.R.332 ; *Govind v. State of M.P.*, AIR 1975 SC 1378; *State of Maharashtra v. Madhukar*, AIR 1991 SC 207; *State of U P v. Shah Medicine*, AIR 1969 SC 1234; *State of Maharashtra v. Basanti Bai*, AIR 1986 SC 1466; *P.U.C.L. v. Union of India*, (1997) 1 SCC 301; *Mr. 'X' v. Hospital 'Y'*, (1998) 8 SCC 296.

7 See, *Govind v. State of M.P.*, AIR 1975 SC 1378.

8 In the following cases it was held by the court that right to privacy encompasses the right to refuse medical treatment: *Saltz v. Perlmutter* (1978, Fla App D4) ; *Superintendent of Belchertown State school v. Saikewicz* (1977, Mass); *Lane v. Candura*, 376 NE2d 1232; *Surenām v. Society of Valley Hospital*, 383 A2d 785, referred in Mason & Mc Call Smith, *Law and Medical Ethics*, (1991). (In this case the court indicated that an individual's right to privacy encompasses the right to choose or reject a cancer treatment on the advice of a licenced doctor); *Re Quinlan* 50 L Ed 2d 289 (it was the first U.S. case in which the court decided that the right to privacy encompasses the right to refuse treatment notwithstanding the fact that it will ultimately lead the person to the death. Court categorically said that State interest theory in the individual life doesn't apply when a person refuses the medical treatment. In effect in the democracy the individual is the sovereign so autonomous. No one can claim monopoly over the life of the individual.)

9 See generally, Mathew, Dayna Rowen, *The terminally Ill Condition in Virginia's Natural Death Act*, 67 *Va.L. Rev.* 749 (1987) at p.781.

choice<sup>10</sup> notwithstanding the fact that it may be detrimental to his life.<sup>11</sup> It is further submitted that when an individual chooses not to be treated and thereby shortens his life, he can't be prevented from doing so by applying the state monopoly theory (state interest theory) because in a democracy the individual is sovereign. Individual is an autonomous body over whom nobody can assert his right.<sup>12</sup> This right, however, is not absolute. The right of the patient to abstain from medical treatment must be balanced against the interests of the State. The four State interests most commonly recognised by the courts in this regard are<sup>13</sup> :

- 1) the protection of third parties;
- 2) the prevention of suicide;
- 3) the protection of the ethical integrity of the medical community; and
- 4) the preservation of life.

Therefore, a patient has the right to privacy, which encompasses the right to refuse the medical treatment.

## ***II. Common Law Right to Self-determination<sup>14</sup> and the Due Process Clause under Article 21***

A person has a right to self-determination under common law.<sup>15</sup> The right to self-determination provides for individual autonomy, human dignity, self-

<sup>10</sup> In *Superintendent of Belchertown v. Saikewicz and Satz v. Perlmutter*: it was the opinion of the court that Mr. McLellan has legal and moral right to make this decision. He has the uncontrolled right to control his own destiny under the right to privacy.

<sup>11</sup> See, Rhoden, Nancy, K., *Litigating life and Death*, 102, Harv. L. Rev., 418 (1988), at p. 420.

<sup>12</sup> See, *P.Rathnam v. Union Of India*, (1994) 3 SCC 413: the Supreme Court categorically pronounced that individual is sovereign in the democracy.)

<sup>13</sup> *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 740-741, 370 N.E.2d 417, 425 (1977) ; see also *In re Conroy*, 98 N.J. 321, 348-349, 486 A.2d 1209, 1223 (1985), cited from, Note, *Doctor Patient Dialogue: A second Opinion On talk Therapy Through Law*, 30 Yale L.J., 458 (1981).

<sup>14</sup> First comprehensive self determination test was laid down in *Cantebury v. Spence*, 409 US 1064 (1972).

<sup>15</sup> Mason & Mc Call Smith, *Law and Medical Ethics*, 65 (1991).

consciousness<sup>16</sup> and the right to choose.<sup>17</sup> The right to self-determination speaks about bodily integrity of an individual, encroachment upon which constitutes battery in the medical profession.

The fundamental ethical principle of the right to self determination was stated by Justice Cardozo in the case of *Schloendorff v. Society of New York Hospital*<sup>18</sup> when he said:

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

This principle underpins the common law concerning consent to treatment in the UK. *In Re T*<sup>19</sup>, Lord Donaldson set out the position as follows:

“An adult patient who suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it, or to choose one rather than another of the treatments being offered... This right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent.”

More recently, this right of self-determination was reaffirmed in *St. George’s Health Care NHS Trust v. S*<sup>20</sup>. In this case, having regard to the right of an individual to personal autonomy, a pregnant woman’s choice to refuse medical treatment at the risk of death was upheld as valid under common law.

It is further submitted that all the rights of an individual rest upon the individual’s right to self determination and for that purpose Article 21 of the Constitution is broad enough to include it.<sup>21</sup> According to the self-determination theory, a competent patient has the right to define his best for medical treatment, hence a patient should be able to withdraw his consent at any time and stop

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16 See, *supra*, n. 7; Note, *Doctor Patient Dialogue: A second Opinion on Talk Therapy Through Law*, 30 Yale L.J., 458 (1981), at pp.471-472.

17 *Sidway v. Board of Governors of the Bethlem Royal Hospital and Maudsely Hospital*, [1985] AC 817 :the Court held that a patient has the absolute right to choose medical treatment. This right of choice is not limited to decisions, which other might regard as sensible. It exists notwithstanding that the reasons for making choice are rational, irrational, unknown or even non-existent.

18 (1914) 211NY 125, cited from Mason & Mc Call Smith, *Law and Medical Ethics*, 67 (1991).

19 (1992) 9 BMLR 46, cited from Mason & Mc Call Smith, *Law and Medical Ethics*, 35 (1991).

20 [1998] All ER 673, cited from Mason & Mc Call Smith, *Law and Medical Ethics*, 106 (1991).

21 See, Seervai, H.M., *Constitutional Law of India*, (1993).

treatment.<sup>22</sup> Therefore, a patient has the right to self-determination under Article 21 of the Constitution and this right includes right to forego medical treatment.<sup>23</sup>

### III. Does a Patient Have the Freedom of Conscience under Article 25 of the Constitution?

Under Article 25 of the Constitution, a person has been invested with freedom of conscience and religion.<sup>24</sup> In *Holmes v. Silver Cross Hospital*<sup>25</sup>, the Court upheld the right to refuse treatment because of religious beliefs. In a catena of cases, the Court held that a person has the right to refuse treatment on the ground of religious beliefs, even if the practice of religious beliefs lead the person to the inevitable death.<sup>26</sup> These American precedents have bearing in the Indian Context as the first Amendment to the American Constitution also guarantees the freedom of conscience and religion to their citizens. In *Narayan Nambudripad v. Madras*<sup>27</sup> the Court relied upon the American precedents establishing freedom of conscience and religion. The Freedom of conscience is also a corollary to the right to self-determination under the common law. Therefore, the denial of the right to refuse medical treatment would be a violation of his right to free exercise of conscience<sup>28</sup> and religion under the article 25 of the Constitution.<sup>29</sup>

22 See, Note, *Informed Consent and Dying Patient*, 83Yale L. J.(1974) at pp.1632-1664.

23 *In re colyer*, 660 P.2d 728(1983) ; *In re Hamlin*,689 P.2d 1372(1984): In these two cases court viewed that common law right to self determination includes right to forego a medical treatment. See, e.g., *In re L.H.R.*, 253 Ga. 439, 321 S.E.2d 716 (1984) (basing right to self- determination on the federal right to privacy); *Corbett v. D'Allessandro*, 487 So.2d 368 (Fla.App. 1986) (basing right to self- determination on state Constitutional guarantees of privacy), cited from, Mason & Mc Call Smith, *Law and Medical Ethics*, 38 (1991): basing right to self-determination on state Constitutional guarantees of privacy.

24 See generally, Gravey, *Freedom of Choice in Constituional Law*, 94 Harv. L. Rev. 1756 (1981); Marcus, *The Forum of Conscience; Applying Standards in Free Exercise*, 80 Duke L.J. 1217 (1973); See also, Kamisar, *Some Non-religious view Against proposed Mercy Killing Bill*, 42 Minn. L. Rev., (1958) at pp.182-198; Note, *Burden on the free Exercise of religion: A subjective Alternative*,102 Harv. L. Rev. (1989) at pp.1258-1270.

25 340 F. Supp. 125

26 (I) *Montgomery v. B.R.K.C.E.R.Association*, Cal App. 3d 447.

(II) *Re Osborne*, 294 A2d 372.

(III) *Re Estate of Brooks*, 205 NE2d 435.

(IV) *RE Melideo*, 390 NYS2d 523.

27 AIR 1954 Mad. 385.

28 Marcus, *The Forum of the Conscience: Applying standard under free Exercise Clause*, 80 Duke L. J.,(1973) at pp.1217-1254.

29 Devlin, *Mill Liberty on Morals*, 32 U.Chi.L.Rev. (1965) at pp. 215-280.

**IV. Does a Patient have the Freedom to Die with Dignity<sup>30</sup> under Article 21 of the Constitution?**

A person has the freedom to die<sup>31</sup> with dignity under the Article 21 of the Constitution of India. Article 21 provides for the protection of life and personal liberty. The freedom to die comes under personal liberty, hence the freedom to die is not in contravention with right to life. This right is clearly brought out in *Smt. Gian Kaur v. State of Punjab*<sup>32</sup>, where a Constitutional Bench observed:

“A question may arise in the case of a dying man, who is terminally ill or in a persistent vegetative state...this ambit of cases may fall within the ambit of the right to die with dignity *as part of the right to live with dignity.*”<sup>33</sup>

Human dignity is a descriptive and value-laden quality, encompassing self-determination and the ability to make choices. To retain a similar level of control over dying as one has exercised during one's life is seen by many as achieving death with dignity.<sup>34</sup> Therefore, it is submitted that a person has a right to refuse medical treatment, which is supported by one's right to privacy, religion, self-determination and the freedom to die with dignity.

**(B) The Premise of Criminal Law<sup>35</sup>: Does the Right to Refuse Medical Treatment imply Abetment of Suicide?**

Section 306 of the Indian Penal Code<sup>36</sup> is not applicable to cases involving the right to refuse medical treatment. There is no act on the part of the Doctor, which leads to the patient committing suicide. Voluntary passive euthanasia doesn't involve physician assistance. In voluntary passive euthanasia death results from selective non-treatment because consent to treatment is withheld, It is therefore legally permissible while active euthanasia is prohibited. Voluntary passive euthanasia (the right to refuse medical treatment) and active euthanasia are separable. The essence of the distinction lies in the means to obtain the same end,

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30 Sustein, R. Class, *The Right to Die*, 108, Yale L. J. (1997) at pp. 1123-1163; Biggs Hazel, *Euthanasia and Death With Dignity: Still Poised on the Fulcrum of Homicide*, Crim. L. Rev. (1996) at pp.878-888.

31 See, Bhattacharjee, A.M., *Equality, Liberty and property under the Constitution of India*, (1997) at p.94: Author has argued that *freedom to die* as one of the liberties that a person may rightfully acclaim under the Article 21 of the Constitution.

32 1996(2) SCALE 881 at 888.

33 *Emphasis supplied.*

34 See, Biggs, Hazel, *Euthanasia and death with Dignity*, Crim. L. Rev. 877 (1996) at pp.878-888.

35 Note, *Criminal Liability in Assisting Suicide*, 86 Col. L. Rev. 348 (1986) at p. 398.

36 Hereinafter referred as 'IPC'

that the taking of active steps implies a control over the way in which an event occurs. The doctor who administers the drug intended to end the life of a suffering patient determines the moment and manner of the patient's death. The action of the drug changes the physical cause of death and this is a matter of importance. This process is quite different from allowing another agency -illness to cause death.<sup>37</sup> If section 306 prohibits voluntary passive euthanasia (the right to refuse medical treatment), it would violate Articles 21 & 25 of the Constitution. Hence, it would render sec. 306 as unconstitutional.

Therefore, it is submitted that there is no abetment of suicide in honouring the patient's right to refuse medical treatment and voluntary passive euthanasia is permissible, otherwise Sec.306 of the I.P.C. would violate Article 21 of the Constitution.

### **(C) Tortious Liability of a Doctor: Various Issues and Defences Examined**

Does the doctor have a duty to intervene, if a terminally ill patient wishes to refuse medical treatment even at the cost of death? Or is it the duty of the doctor to respect the patient's autonomy and allow him to die?

Honouring the patient's autonomy and the right to refuse medical treatment cannot be construed as negligence on the part of the doctor in performing his professional duties. The burden of proof lies on the respondent who claims compensation asserting that there has been negligence on the part of doctor, which resulted in the wrongful death of the patient.

#### ***I. Does a doctor have a duty to treat a Patient when he denies consent to it***

Common law recognises the right to be free from bodily invasion.<sup>38</sup> From this right to be free from bodily invasion developed the doctrine of informed consent.<sup>39</sup> The doctrine of informed consent declares that in the absence of any emergency situation, medical treatment may not be imposed without the patient's informed consent.<sup>40</sup> A logical corollary to this doctrine is the patient's right, in general, "to refuse treatment and to withdraw consent to treatment once begun."<sup>41</sup>

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37 See, Jean Davies, *Raping and Making Love are Different Concepts; so are Killing and Euthanasia*, 14 J. Med. Ethics 148 (1988) at p. 149.

38 Mason & Mc Call Smith, *Law and Medical Ethics*, 77 (1991).

39 See *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 129-130, 105 N.E. 92, 93 (1914) (Cardozo, J.)

40 *Moure v. Raeuchle*, 529 Pa. 394, 404, 604 A.2d 1003, 1008 (1992).

41 See, Titez, Gerald F., *Informed Consent In the Prescription Drug Context; The Special case*, 61 Wash. L. Rev. 367 (1986) at p. 417.

Courts have unanimously concluded that<sup>42</sup> this right to self-determination does not cease upon the incapacitation of the individual. It is submitted that doctor does not have any duty to treat the patient when he denies so.

In the leading case on consent to medical treatment, *Sidaway v. Governors of Bethlem Royal Hospital*<sup>43</sup>, the House of Lords, confirming that the *Bolam* test applied, ruled that how much and what kinds of information a doctor should disclose in order to inform a patient before obtaining consent, is a matter of clinical judgment. The *Bolam* test broadly lays down that the standard of the ordinary skilled man exercising and professing to have that special skill, it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular act.<sup>44</sup> Thus the information to be given to the patient before surgery is not a matter of meeting criteria which have been objectively determined, but a matter for the doctor to decide. Moreover, it is irrelevant that there is an alternative body of medical opinion that would have provided the patient with more information, as long as a body of opinion exists which supports what the defendant did. Ultimately this is a matter for expert evidence, but if a doctor can demonstrate that a reasonably competent practitioner in a similar situation would not have mentioned a certain risk, he or she can escape liability.<sup>45</sup>

The House of Lords has recently modified the *Bolam* test in the case of *Bolitho v. City and Hackney Health Authority*<sup>46</sup>, in which it was decided that a judge may on certain rare occasions choose between two bodies of medical opinion, if one is to be regarded as “logically indefensible”. However, for the time being this new approach does not extend to cases involving consent to treatment. Lord Browne Wilkinson specifically excluded consent cases when he said:

“In cases of treatment and diagnosis there are cases where, despite a body of professional opinion sanctioning the defendant’s conduct, the defendant can properly be held liable for negligence (I am not here considering questions of disclosure of risk).”

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42 See, e.g., *In re Colyer*, 99 Wash.2d 114, 660 P.2d 738 (1983); *Mack, supra*; *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976), cited from Mason & Mc Call Smith, *Law and Medical Ethics*, 41 (1991).

43 [1985] 1 All 643.

44 *Bolam v. Friern Hospital Management Limited*, [1957] 2 All ER 118 at p. 121.

45 There have been one or two cases in the UK (e.g. *Smith v Tunbridge Wells Health Authority* [1994] 5 Med LR) in which the Courts have taken a more pro-patient approach to the issue of information provision, but these have been decided only at High Court level and the *Sidaway* principle remains firmly entrenched in UK law.

46 (1997) 39 BMLR 1, cited from Mason & Mc Call Smith, *Law and Medical Ethics*, 25 (1991).

Today a relationship between a patient and a doctor is marked by a fiduciary character. In the modern medical practice a patient has the right to informed consent and this right to informed consent presupposes the right to refuse medical treatment.<sup>47</sup> Informed consent involves two vital elements: the patient must be given information on the risks involved in the treatment, and he must assent to the treatment.<sup>48</sup> Without proper consent, administration of a treatment would amount to battery<sup>49</sup> under the common law.<sup>50</sup> Therefore, a doctor would be right in refusing to administer treatment to a patient who has withheld consent for such treatment.<sup>51</sup>

## II. Defence of Contributory Negligence

If negligence is pleaded on the part of doctor, he can take the defence of contributory negligence on the part of patient in the case of tortious liability.<sup>52</sup> The doctrine of contributory negligence seems to be founded upon the *maxims volenti non fit injuria and in jure non remota causa sed proxima spectatur*. The burden of proof in such cases is on the defendant. Where it cannot be established as to what extent the negligence of the plaintiff or that of the defendant has contributed to

47 See generally, Sheltz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 Yale L. J. 219 (1985) at p. 277.

48 See generally, Titez, Gerald F., *Informed consent in the prescription drug context: The Special Case* 61 Wash. L. Rev. (1986) at pp. 252-270; Note, *Informed consent and The Dying Patient*, 83 Yale L. J.(1981) at pp. 1632-1664; Sustein, R. Cass, *Incomplete Theorised Agreement*, 108 Harv. L. Rev. (1995) at pp. 1733-179.

49 Battery involves intentionally bringing about a harmful or offensive contact with the person of another without consent. The civil action has a dual purpose of providing protection to the individual against bodily harm and also against any interference with his or her person, which is offensive to a reasonable sense of dignity. For this tort to be committed it does not matter that the interference was only trivial and did not involve pain. There need be no intention to hurt the plaintiff, but only an intention to apply physical force of some kind. In medical cases, examples of when battery may be committed include circumstances when the patient:

- Is treated against his or her will?
- Consents to one treatment but receives another or an additional treatment.
- Is given treatment without being told that this will happen?
- Is treated under duress?
- Agrees to treatment after being provided deliberately with information which is wrong.

50 See, *Mohr v. William* 104N.Y.12(1905) ; *Pratt v. Davis* 79 N.E. ; see also, *Hunter v. United States*, 236 F.Supp.4119(In this case court held that patient party won't be entitle for the compensation as the patient himself by refusing to medical treatment contributed to negligence, hence the claim must fail)

51 See, *Mc Coid, Re Appraisail for the liability for unauthorised treatment*, 41 Minn.L.Rev. (1965) at pp.969-1042.

52 See, *Ratanlal & Dhirajlal, Law of Torts*, (1997) at pp.502-510.

bring about the injury, the suit will fail.<sup>53</sup> Where the negligence of the both the parties has caused death or injury, the common law rule is that the party who alleges negligence is to fail.<sup>54</sup> However, this rule is subject to the last opportunity rule<sup>55</sup> In the last opportunity rule the single question involved is whose negligence was it that substantially caused the damages.<sup>56</sup> In the case, where a patient refuses medical treatment the last opportunity is not with the doctor but it is largely dependent upon the consent of the patient. Had the patient agreed to the treatment, he would not have faced the drastic consequence of his death. A patient could have easily avoided the prospect of death by undergoing the prescribed medical treatment. Therefore, a patient voluntarily exposing himself to death by foregoing medical treatment cannot seek tortious remedy, as he is the sole contributor to his own death. Hence, a suit claiming damages for the wrongful death will fail.

Therefore, there is contributory negligence on the part of the patient and a claim for compensation against the doctor would fail.

### **III. Surrogate Consent<sup>57</sup> and Protection of the Best Interest of the Patient**

There are various legal theories on which authorisation to terminate life support may be predicated. The approach taken is to allow a close family member to exercise “substituted judgement” on behalf of the patient. In exercising “substituted judgement,” the surrogate considers the patient’s personal value system for guidance. The surrogate considers the patient’s prior statements about and reactions to medical issues, all the facets of the patient’s personality that the surrogate is familiar with, his or her relevant philosophical, theological and ethical values in order to extrapolate what course of medical treatment the patient would choose.

The substituted judgement approach “is intended to ensure that the surrogate’s decision as much as possible should be the decision that the incompetent patient would make if he or she were competent. Even where the individual has not expressed thoughts concerning life-sustaining treatment, the patient’s preferences can still be ascertained by referring to all aspects of his or her personality.”<sup>58</sup>

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53 See, *Vidya Devi v. Madhya Pradesh State Transport Corporation*, AIR 1975 MP 89. For the latest development in the law of contributory negligence, see, Nishant Kumar Singh & Nisha K. Uberoi, *The law of Torts*, (1999) IX MOL at pp.199, 201.

54 *Butterfield v. Forrester*, (1809) 11 East 60

55 *Davies v. Mann*, (1842) 10 M&W 546.

56 *Supra*, n.24.

57 *Supra*, n.7

58 See *Estate of Longeway*, 133 Ill.2d at 49-50, 549 N.E.2d at 299-300.

There should be “clear and convincing evidence of the patient’s intent to withdraw life support”.<sup>59</sup> This is the most stringent approach. This standard requires “[n]othing less than unequivocal proof” of the patient’s express wishes as to the decision to terminate life support is at issue.<sup>60</sup>

If this test is to be applied to all patients who did not have the prescience or the sophistication to express clearly and unmistakably their wishes on this precise matter they would not be able to have life support removed. For those individuals, the choice concerning medical treatment would not be an extrapolation based upon their individual beliefs. Rather, the “choice” would be dependent simply upon how far the frontiers of medical science have advanced: if the life sustaining procedures were available, they would be automatically administered. Thus, it is submitted that the substituted judgement standard is the proper approach.

It is suggested that a close family member is well suited to the role of substitute decision-maker in such circumstances.<sup>61</sup> Close family members are usually the most knowledgeable about the patient’s preferences, goals, and values; they have an understanding of the nuances of his personality that sets him apart as an individual.<sup>62</sup> In addition to the greater knowledge of the patient’s personal views, close family members have a special bond with the patient. “Our experience informs us that family members are generally most concerned with the welfare of a patient.”<sup>63</sup>

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59 It is notable here that the term “clear and convincing evidence” in this context refers to the requirement that the individual in question must have stated in an explicit fashion the exact treatment desired were the patient to lapse into various medical conditions. The term “clear and convincing evidence” is used more commonly, however, as a burden of proof. In that context, the standard refers to that quantum of evidence necessary for a party to establish a point. For further illumination on the distinction *see generally* Comment, *The Right to Die*, 96 Dick.L.Rev. 649, 651 and 665-669.

60 *In re Westchester County Medical Center (O’Connor)*, 531 N.E.2d 607, 612 (N.Y. 1988). *See also Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988), *aff’d.*, *Cruzan v. Director, MO. Health Dept.*, 497 {11} U.S. 261 (1990) (court found that PVS patient’s expressions to a roommate that she would not want to be maintained on life support if she were ever to become a “vegetable,” and other similar observations, did not meet the clear and convincing evidence standard because the statements did not deal specifically with the withdrawal of artificial hydration and nutrition. insufficient to meet the clear and convincing evidence standard; the PVS patient was thus maintained on life-support.)

61 *Accord see, e.g., Colyer*, 94 Wash.2d at 127, 660 P.2d at 745-746; *Foody v. Manchester Memorial Hospital*, 482 A. 2d 713 (Conn. Super. Ct. 1984) ; *Jobes*, 108 N.J. at 415-417, 529 A.2d at 445, *referred in* Mason & Mc Call Smith, *Law and Medical Ethics*, 132 (1991).

62 *See also Jobes*, 108 N.J. at 416, 529 A.2d at 445.

63 *Jobes*, 108 N.J. at 416, 529 A.2d at 445.

Furthermore, concomitant to the surrogate's exercise of the patient's right to refuse treatment, the surrogate must also obtain written statements of two doctors qualified to evaluate the patient's condition. These statements must certify that the patient has been diagnosed as being in a permanent vegetative state. If the patient has an attending physician, that physician shall also prepare a statement.<sup>64</sup> It is submitted that surrogate consent can't be taken when the patient himself has expressed his wish and protest against treatment. Surrogate consent<sup>65</sup> should be permissible, only when, the patient does not express his own view about the proposed medical treatment and not competent enough to express his will. Furthermore, surrogate consent is deniable, especially when it runs in counter to the patient expressed view on that point. In several cases courts have decided that even in the incompetent state surrogate consent can't be taken.<sup>66</sup>

Therefore, it is submitted that surrogate consent should not be taken when it runs counter to the previous directive given by a patient.

### Conclusion

*"The conceptual confines of death are forever in flux. In what is a crisis of modern technology, there is a high possibility of an individual being compelled to exist, by artificial prolongation of his life, against his will."*<sup>67</sup>

In the light of the above-mentioned authorities and arguments, the attempt has been to establish that the right to refuse medical treatment has sound theoretical footing. In essence, the entire understanding of the right to refuse medical treatment is based upon the sound tenet of informed consent and notion of patient's autonomy. Considered judicial opinions on the subject unequivocally establish the patient's right to refuse medical treatment. However, there is controversy about its absolute character. Limitation of State-interest theory circumvents its broad scope only to

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<sup>64</sup> See also, *Jobes, ibid.*

<sup>65</sup> See, W.J.S.O., *Proxy Decision-Making for the Terminally ill: the Virginia Approach*, 70 Va.L. Rev.(1987) at pp.749-81.

<sup>66</sup> Mason & Mc Call Smith, *Law and Medical Ethics*, 107 (1991).

<sup>67</sup> Nishant Kumar Singh & Srishti Jha, *Euthanasia is Illegal in India: Exploding the Myth*, 5 Law & Medicine 297 (1999) at p. 300.

terminally ill patients or patients who are in persistent vegetative state.<sup>68</sup> According to one commentator, "A competent patient, even one who is not terminally ill, has a right to refuse medical treatment is virtually absolute one"<sup>69</sup> Further, the right to refuse medical treatment has posed complex questions and serious difficulties in the case of surrogate consent or proxy consent. There are contradictory opinions on its legal admissibility.

There is a crying need for legislative intervention so as to formulate certain guidelines for surrogate consent. This legislative measure, because of the extensive range of possibilities for abuse and misuse by the relatives in collusion with some unscrupulous medical professionals should be drafted after thorough empirical studies of samples drawn from the medical profession normally dealing with such terminally ill. The purpose is to identify the parties who stand for and against the measure and locate determinate variables and situations for people's apathy or sympathy. Predictive studies are useful in gauging the possibilities of misuse of proposed measure. Organised predictive research outside the legislature is a condition precedent for meaningful lawmaking today.<sup>70</sup>

In preparation of this apparent inevitability, it is suggested here that the surrogate consent must have both convincing evidence of patient's desire not to have life sustaining intervention and medical information equivalent to that which a competent patient would have had before consenting to or rejecting the treatment.<sup>71</sup> This approach promotes a patient's common law and the Constitutional right of personal choice. It also appropriately incorporates the traditional reliance of health care decision making on the doctrine of informed consent.

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68 A recent article published in The New England Journal of Medicine introduced a distinction between persistent and permanent vegetative states. The article stated that "[a] wakeful unconscious state that lasts longer than a few weeks is referred to as a persistent vegetative state . . . . A permanent vegetative state, on the other hand, means an irreversible state . . . ." Multi-Society Task Force on PVS, *Medical Aspects of the Persistent Vegetative State* (Pts. 1 & 2), 330 *New Eng. J. Med.* 1499, 1501 (1994) (emphasis supplied). Based on review of prior PVS cases, the article concluded that where a persistent vegetative state was brought on by traumatic injury, the state can be judged permanent twelve months after the occurrence of the injury; the article noted that recovery after twelve months is exceedingly rare. *Id.* at 1575. For a discussion of one such emergence from a permanent vegetative state, see Nancy L. Childs, M.D. & Walt N. Mercer, *Brief Report: Late Improvement in Consciousness After Post-Traumatic Vegetative State*, 334 *New Eng. J. Med.* 24 (1996)

69 See, Jack Schwartz, *Writing the Rules of Death: State Regulation of Physician Assisted Suicide*, *Journal of Law Medicine and Ethics*, 24 (1996) at pp. 207-16.

70 See, Rajkumari Agrawala, *Indian legal Research*, 24 *JILI* 470 (1982) at 472.

71 See, Nancy Rhoden, *Litigating Life and Death*, 102 *Harv. L. Rev.* 402 (1988) at p. 421.