CONSENT IN MEDICAL NEGLIGENCE: LEGAL CONSEQUENCES OF UNAUTHORISED PROCEDURES AND GHOST SURGERIES

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ABSTRACT

Consent is one of the most fundamental principles in medical jurisprudence. Except in specific circumstances, such as proxy consent or medical emergencies, no procedure can be lawfully performed without the patient's informed consent. However, situations persist where consent remains dubious, leading to unauthorised procedures being performed on the patient, the necessity of which may be debatable. A novel form of such a violation is ghost surgery, where the procedure is performed by someone other than the doctor to whom the patient consented. Such instances often go unnoticed, and while they are a clear breach of the patient's consent, spirit surgeries have not been adequately recognised in Indian law, giving rise to legal and ethical ambiguities and potential dangers to the patients themselves.

Keywords: Consent, Patient Autonomy, Ghost Surgery, Unauthorised Medical Procedures, Healthcare Law.

INTRODUCTION

In India, doctors are often described as an incarnation of God, with the duty and responsibility to save and protect patients. For a medical practitioner, there can be no greater joy than knowing their actions saved someone from death. However, as with every field, the medical field is highly regulated, more so due to the considerable risks involved. Medical negligence is not uncommon, although all precautions are taken. Medical negligence may be defined as "want of reasonable care and skill or wilful negligence, on the part of a medical practitioner in the

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treatment of his patient with whom a professional attachment is established to lead to his bodily injury or the loss of his life".[1]

The law presumes that a medical professional uses a reasonable degree of skill, care, knowledge and prudence to treat his patient to the best of his judgment and ability. Still, he is not liable for an error in judgment or diagnosis. To err is human, and a medical professional cannot be held liable for it. In the State of Haryana v. Santra,[2] the Supreme Court held that every doctor must act with a fair, reasonable and competent degree of skill. This is known as an 'implied undertaking' by a member of the medical profession. While a general medical practitioner is expected to use only the ordinary degree of skill and knowledge that other general practitioners of his qualifications use, a specialist is expected to possess and exercise a higher degree of skill and learning in his special line and is judged by comparison with other specialists engaged in the same line.[3]

In the landmark case of Indian Medical Association v. V.P. Santha,[4] the Supreme Court decisively included the healthcare profession under the definition of 'service' under the Consumer Protection Act, 1986.[5] The repeal of the 1986 Act by the 2019 Act[6] made no change to such an inclusion.[7] Currently, the ambit of the 2019 Act includes all medical services offered by private and government doctors and hospitals, exempting only those that offer free service to all patients at all times.

However, where the Consumer Protection Act does not apply, tort law remains a key avenue for legal recourse. Moreover, even in cases where medical services are provided free of charge, tort law ensures accountability. Courts have held that negligence claims may arise in situations such as incorrect blood transfusions, retained surgical instruments, unauthorised removal of organs and incorrect medication administration.[8]

One of the most serious concerns in medical negligence cases is the unauthorised performance of procedures, including ghost surgeries, where a different or unapproved surgeon operates on

[1] Jaisingh P Modi, A Textbook of Medical Jurisprudence and Toxicology (26th edn, LexisNexis 2011) 109
[2] State of Haryana v Santra, (2000) 5 SCC 182
[3] Modi (n 1)
[4] Indian Medical Association v VP Santha, (1995) 6 SCC 651
[5] Consumer Protection Act 1986, s 2(o)
[6] Consumer Protection Act 2019, s 2(42)
[7] Medicos Legal Action Group v Union of India, 2021 SCC OnLine Bom 3696
[8] Laxmish Rai, 'Doctor - Patient Relationship and Medico Legal System - A Comparative Study with USA, UK, Australia and India' (2016) 2(1) IJLS 62

an unknowing patient. Such practices violate the principles of patient autonomy and informed consent, which are fundamental to medical law and ethics. Recognising the gravity of medical negligence, Section 106(1) of the Bharatiya Nyaya Sanhita, 2023,[9] prescribes imprisonment of up to two years and a fine for a registered medical practitioner whose negligence results in a patient's death. Additionally, doctors can also be held vicariously liable for the negligent actions of their employees or subordinates.

While the law rightly exists to hold medical professionals accountable for negligence or ethical violations, there are instances where individuals attempt to exploit these protections to unfairly target doctors. Although the legal system is designed to safeguard patients' rights and ensure informed consent, it must also prevent undue harassment of medical practitioners who act in good faith. Medicine is an inexact science, and not every unfavourable outcome stems from negligence. Therefore, the law must strike a careful balance by protecting patients from genuine harm while also shielding healthcare providers from baseless or opportunistic claims.

This paper explores the legal consequences of ghost surgeries and unauthorised medical procedures, with a focus on the evolving framework of patient rights and medical accountability in India. It examines key statutes, judicial precedents, and the doctrinal basis of informed consent to assess how the law addresses such violations. Through case analysis and legal interpretation, the paper highlights the critical role of consent in medical jurisprudence and aims to provide insight for both medical practitioners and the judiciary on navigating these complex ethical and legal challenges.

ELEMENTS OF MEDICAL NEGLIGENCE

Modern tort law differentiates between injuries inflicted as a result of intentional conduct and those resulting from negligence. From the judgments given by the Supreme Court in Poonam Verma v. Ashwin Patel[10] and Nagrik Sangarsh Samiti v. Union of India,[11] it can be concluded that negligence mainly comprises three components:[12]

1. A legal duty to exercise due care on the part of the party complained of towards the party complaining about the former's conduct within the scope of the duty.

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[9] Bharatiya Nyaya Sanhita 2023, s 106(1)
[10] Poonam Verma v Ashwin Patel, AIR 1996 SC 2111
[11] Nagrik Sangarsh Samiti v Union of India, ILR (2010) 4 Del 293
[12] Akshay Sapre, Ratanlal & Dhirajlal: Law of Torts, (29th edn, LexisNexis 2023) 476

2. Breach of the said duty
3. Consequential damage

A medical professional is in breach of his duty when he fails to meet the standard of care and skill that the law requires of him. The Bolam Test, given in the case of Bolam v. Friern Hospital Management Committee,[13] is the definitive criterion for assessing the standard of care in medical negligence cases. McNair J. held in this decisive judgement that a medical professional cannot be judged against an ordinary individual or one who does not possess the special skills that the former does.

"...The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent. It is well-established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art."

In the case of Dr. Laxman Balkrishna Joshi v. Dr. Trimbark Babu Godbole and Anr.,[14] and A.S. Mittal v. State of U.P.,[15] it was laid down that when a patient consults a doctor, the doctor owes to his patient certain duties including:

1. Duty of care in deciding whether to undertake the case
2. Duty of care in deciding what treatment to give
3. Duty of care in the administration of that treatment

A breach of any of the above duties may give rise to action for negligence, and the patient may, on that basis, recover damages from his doctor. In general, in a case of medical negligence, the burden of proof lies with the plaintiff, who has to prove the presence of duty, breach of care and the consequential damages suffered by him.

In the leading case of Jacob Mathew v. State of Punjab,[16] the Court came to the following conclusions regarding medical negligence, laying down comprehensive guidelines for the professional:

[13] Bolam v Friern Hospital Management Committee, (1957) 1 WLR 582
[14] Dr Laxman Balkrishna Joshi v Dr Trimbark Babu Godbole and Anr, AIR 1969 SC 128
[15] AS Mittal v State of UP, AIR 1989 SC 1570
[16] Jacob Mathew v State of Punjab, (2005) 6 SCC 1

- Mere deviation from everyday professional practice is not necessarily evidence of negligence.
- A mere accident is not evidence of negligence.
- An error of judgment on the part of a professional is not negligence per se.
- Simply because a patient has not favourably responded to a treatment or a surgery has failed, the doctor cannot be held liable per se by applying the doctrine of res ipsa loquitur.

In Samira Kohli v. Dr. Prabha Manchanda,[17] it was held that a doctor acting according to normal care and a recognised medical practice could not be considered negligent merely because a body of opinion takes a contrary view. Moreover, as was held in Hatcher v. Black,[18] a doctor cannot be held liable simply because one of the risks inherent in the operation took place or if he made an error in judgment. Liability can only be insured if the doctor falls short of the reasonable standard of medical care.

Similarly, in the case of Dr. Kunal Saha v. Dr. Sukumar Mukherjee and Ors.,[19] the National Commission held that an error of judgment in diagnosis or failure to cure a disease does not necessarily mean medical negligence. These judgements rely on the Bolam principle,[20] according to which a mere misjudgement or error in medical treatment by itself would not be decisive of negligence towards the patient and the knowledge of medical practice and **procedure** available at the time of the operation, and not at the date of trial, is relevant.

Consent in Medical Jurisprudence: It is an internationally recognised rule of medical law that a patient cannot undergo a procedure without their consent. The concept of informed consent is rooted in the Nuremberg Code of 1947 and is reinforced by the Declaration of Helsinki in 1964. It establishes that no medical procedure should be performed without the patient's voluntary agreement.[21] It is the patient's choice to undergo treatment, and the doctor only plays the role of an advisor. The doctor must respect the patient's choice even if the reasons given by the patient for refusing consent seem absurd or misplaced.[22] Consent in the

[17] Samira Kohli v Dr Prabha Manchanda, (2008) 2 SCC 1
[18] Hatcher v Black, (1959) Times, 2 July
[19] Dr Kunal Saha v Dr Sukumar Mukherjee and Ors, III (2006) CPJ 142 (NC)
[20] Bolam (n 13)
[21] Anmol Mahani, Rudranath Zadu, 'The role of consent in Indian judiciary: Implications for cancer treatment practices' (Indian Journal of Forensic and Community Medicine, 26 November 2024) <https://doi.org/10.18231/j.ijfcm.2024.034>
[22] Rai (n 8)

context of a doctor-patient relationship means the patient grants permission for an act to be carried out by the doctor, such as a diagnostic, surgical or therapeutic procedure.[23] If a medical practitioner attempts to treat a person without valid consent, they will be liable under both tort and criminal law.[24]

The term informed consent was first used in 1957.[25] "Informed consent" is defined in Taber's Cyclopaedic Medical Dictionary thus: "Consent that is given by a person after receipt of the following information: the nature and purpose of the proposed procedure or treatment; the expected outcome and the likelihood of success; the risks; the alternatives to the procedure and supporting information regarding those alternatives; and the effect of no treatment or procedure, including the effect on the prognosis and the material risks associated with no treatment. Also included are instructions concerning what should be done if the procedure turns out to be harmful or unsuccessful."[26]

Consent can be given in the following ways:[27]

Implied Consent: Consent may also be implied by the patient's conduct, such as when he enters the doctor's consultation chamber or follows the doctor's orders. Implied consent is applicable for clinical examination, including pelvic and PR examinations.[28] However, except where consent can be implied, express consent is preferred.

Express Consent: Explicit or express consent is required for all procedures, treatments, surgery and interventions that have commonly known risks to the patients.[29] Express consent may be oral or in writing. Though both these consent categories are of equal value, written consent can be considered superior because of its evidential value.

Surrogate/Proxy Consent: Consent is given by family members or by a person authorised by the patient on their behalf is known as surrogate or proxy consent.

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[23] Samira Kohli (n 17)
[24] Omprakash V Nandimath, 'Consent and medical treatment: The legal paradigm in India' (2009) 25(3) Indian Journal of Urology 343
[25] Paul S Appelbaum, 'Assessment of Patient's Competence to Consent to Treatment' (2007) 357(18) New Eng J Med 1834
[26] Samira Kohli (n 17)
[27] M.S. Pandit, Shobha Pandit, 'Medical negligence: Coverage of the profession, duties, ethics, case law, and enlightened defense - A legal perspective' (2009) 25(3) Indian Journal of Urology 372
[28] National Medical Commission Registered Medical Practitioner (Professional Conduct) Regulations 2023, guideline 5 (NMC Regulations)
[29] ibid

Advance Consent: It refers to consent given by a patient in advance.

The law does not demand that the consent be written or oral. However, the medical practice itself determines the need for written and informed consent. Ideally, written consent is preferred when the patient is to be subjected to anaesthesia (either local or general) or severe pain during the administration of the treatment. There is no mandate that a doctor should always obtain written consent, and that failure to do so would hold him liable.[30] However, proper documentation of the information shared and the consent procedure is recommended by the NMC to prevent denials, misunderstandings and legal action.[31]

According to Regulation 19(A) of National Medical Commission Registered Medical Practitioner (Professional Conduct) Regulations, 2023, "Before performing any clinical procedure, diagnostic or therapeutic, or operation, the RMP (Registered Medical Practitioner) should obtain the signed, documented informed consent of the patient. In case the patient is unable to give consent, the consent of the legal guardian or family member must be taken."[32]

Certain basic information must be presented to the patient when obtaining his consent. The American Medical Association[33] and National Medical Commission[34] have listed the following as the minimum required disclosures: diagnosis (if it is known), the nature and purpose of the recommended intervention or procedure, the burdens, risks and expected benefits of all options, including foregoing any treatment. The conversation with the patient that occurred when going over this information and the patient's decision must be documented in the medical record, in addition to the written consent. In addition, the physician must disclose to the patient whether they have any conflicts of interest, such as being a consultant for a surgical equipment manufacturer.[35]

Further, the patient should be informed about medically recognised alternative measures[36] that could be performed other than the proposed treatment or diagnostic strategy, even if the doctor believes them to be less desirable or effective. It allows the patient to make a truly informed decision regarding what may happen to their body. However, non-medically recognised

[30] Nandimath (n 24)
[31] NMC Regulations, guideline 5
[32] NMC Regulations, reg 19(A)
[33] Christine S Cocanour, 'Informed Consent-It's more than a signature on a piece of paper' (2017) 214 American Journal of Surgery 993
[34] NMC Regulations, guideline 5
[35] Cocanour (n 33)
[36] NMC Regulations, guideline 5

alternatives, such as unproven treatment, need not be disclosed. Nevertheless, there may be an obligation to discuss possible experimental treatment if the information is readily available to a provider using reasonable efforts.[37]

There have been three standards proposed for what information must be given to the patient regarding a procedure:[38]

- The professional practice standard or what a reasonable physician would provide.
- The reasonable person standard is what a reasonable person would expect to hear.
- The "subjective standard" is what a patient needs to know and understand to make an informed decision.

The reasonable physician standard is often inadequate, as the typical physician tells very little; the subjective standard is the most challenging to incorporate into practice, as it requires tailoring information to each patient as per their requirements.[39]

In Samira Kohli v. Dr. Prabha Manchanda,[40] it was held that in India, the extent and nature of information required to be given by doctors to the patient to obtain valid consent is governed by the Bolam test[41] and not by the "reasonably prudential patient" test evolved in Canterbury v. Spence.[42] It is for the doctor to decide, with reference to the patient's condition, the nature of illness and the prevailing established practices, as to how much information regarding the risks and consequences should be given and how they should be couched in the patient's best interest.

The information discussed and disclosed to the patient must be in a language that the patient understands[43], and a translator should be used if required; otherwise, the consent is not considered to be informed. If the patient does not understand the information or has not had an opportunity to discuss it, informed consent may not exist, and the physician may not have fulfilled their legal duty to the patient under these circumstances. Nevertheless, physicians are not required to disclose every risk, however remote, associated with a medical procedure or

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[37] Bryan A Liang, 'Informed consent: Know rules and exceptions, when they apply' (Relias Media, August 1 2003) <https://www.reliasmedia.com/articles/29540-informed-consent-know-rules-and-exceptions-when-they-apply>
[38] ibid
[39] ibid
[40] Samira Kohli (n 17)
[41] Bolam (n 13)
[42] Canterbury v Spence, 464 F 2d 772 (1972)
[43] NMC Regulations, guideline 5

treatment. Further, physicians are not required to disclose risks considered obvious to the patient, considered common knowledge (such as the risk of infection after a surgical procedure), those of which the physician could not have been aware or that were not foreseeable.[44]

The NMC Regulations specify that consent must be taken for all operative procedures, whether major or minor. Moreover, the consent must be procedure-specific. Fresh consent must be taken for every new procedure and must be taken separately for surgery and anaesthesia because the nature of these procedures, as well as the complications, are different. Similarly, a patient undergoing two separate elective procedures needs to give individual consent for each operation. Further, the responsibility of administering the informed consent is on the primary physician, and his name should be on the consent form for all surgical procedures.[45]

The standard consent form for surgery under anaesthesia used by medical practitioners and hospitals should include specific risks and information related to each case, where necessary, and the patient's consent documented for the same.[46]

There are five recognised exceptions when informed consent of the patient is not necessary:[47]

A Public Health Emergency:

- A public health emergency occurs when the health of a population may depend upon adopting specific measures. In this context, consent would not be required.
- An example is the use of quarantine for potential COVID-19 victims to contain the disease.

A Medical Emergency:

- The NMC Regulations provide that in case of an emergency, the doctor should try to obtain consent, but if this is not possible, he must act in the best interest of the patient.[48]

[44] Liang (n 37)
[45] NMC Regulations, guideline 5
[46] ibid
[47] Cocanour (n 33)
[48] NMC Regulations, reg 19(A)

- A medical emergency is when the provider believes that a medical procedure is needed immediately and there is insufficient time to obtain the patient's or their surrogate's consent or the patient is unable to give consent.
- In such a scenario, consent is presumed for the patient. In other words, the patient is presumed to have consented to all relevant, medically appropriate care that should be provided to treat the emergent situation at hand.[49]

When the Patient is Incompetent:

- All adults (persons above the age of 18) are presumed to be competent unless they are determined by a court to be incompetent, either due to reasons of mental illness or other impairments.
- Minors are not presumed to be competent. As a result, they cannot consent to medical treatment and procedures.[50] In these cases, the child's parent or legal guardian must consent on the minor's behalf.[51]

Patient Waiver:

- The patient may delegate the decision-making to the physician by signing a patient waiver.

Therapeutic Privilege:

- A physician is not required to disclose information to the competent patient if he feels that such a disclosure would seriously harm rather than benefit the patient.
- If the use of "therapeutic privilege" becomes necessary, it is important to document the facts and circumstances that led to the decision not to give all of the information to the patient and what information was actually given to the patient. It is also important to document any discussion with the patient's designated surrogate.

It is important to strike the appropriate balance among the fundamental ethical principles of autonomy (the right of individual patients to decide about their treatment), beneficence (the

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[49] Liang (n 37)
[50] NMC Regulations, guideline 5
[51] Hanan Zaki, 'Informed Consent and Unauthorized Treatment' (FindLaw, June 12 2024) <https://www.findlaw.com/injury/medical-malpractice/unauthorized-treatment-and-lack-of-informed-consent.html>

obligation of the physician to take actions intended to benefit their patients and to refrain from actions that are likely to harm) and justice (the obligation to apportion research risks and benefits equitable across the population) along with many practical considerations when obtaining consent.[52]

UNAUTHORISED PROCEDURES AND LEGAL CONSEQUENCES

Unauthorised medical procedures occur when a doctor or medical professional performs a treatment or surgery without the patient's valid and informed consent. Such actions violate the fundamental principle of patient autonomy and can lead to legal consequences under tort, criminal and consumer protection laws. In India, courts have consistently held that performing a procedure without consent, except in emergencies, amounts to medical negligence and may also constitute assault or battery under criminal law. Legal liability in such cases depends on factors such as the nature of the procedure, the absence of consent and the harm caused to the patient.[53]

In a suit under tort law, the patient will have to show two elements to prove their case:[54]

- The doctor performed the treatment or procedure without his or her informed consent.
- Had the patient known of the possible detrimental effects, they would not have undergone the treatment.

Unauthorised Extra-Surgical Actions: Unauthorised extra-surgical actions refer to medical procedures or interventions undertaken by a doctor without the patient's explicit consent. It refers to situations where a patient may have consented to a specific procedure, but a surgeon performed additional steps or an entirely different procedure. Such situations, where actions are taken without obtaining the patient's informed consent, constitute a legal and ethical violation.[55]

In the case of Samira Kohli v. Dr. Prabha Manchanda,[56] the patient visited the doctor regarding persistent menstrual bleeding. On the doctor's advice, the patient consented to undergo a

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[52] Susan S Ellenberg, 'Informed consent: Protection or obstacle? Some emerging issues' (1997) 18(6) Controlled Clinical Trials 628, 633

[53] 'Informed Consent and Unauthorized Treatment' (Hogan Injury) <https://www.hoganinjury.com/personal-injury/medical-malpractice/unauthorized-treatment-and-lack-of-informed-consent>

[54] ibid

[55] Zaki (n 51)

[56] Samira Kohli (n 17)

laparoscopy test for an affirmative diagnosis; the same was also stated on the consent form signed by the patient. After the appellant was put under general anaesthesia and subjected to a laparoscopic examination, the doctor took the consent of the appellant's mother, who was waiting outside, to perform a hysterectomy. Thereafter, the doctor performed an abdominal hysterectomy (removal of the uterus) and bilateral salpingo-oophorectomy (removal of the ovaries and fallopian tubes).

The Court held that the consent given by the patient for a diagnostic laparoscopy did not extend to a full-fledged hysterectomy and bilateral salpingo-oophorectomy. Moreover, in the absence of an emergency, the doctor had no legal authority to proceed with the surgery based on the consent obtained from the patient's mother. Further, consent for hysterectomy did not extend to consent for bilateral salpingo-oophorectomy. While the words "Laparotomy may be needed" were present in the consent form, the Court held that they can only refer to therapeutic procedures that are conservative (for example, removal of chocolate cyst and fulguration of endometrial areas, as stated by the respondent herself as a choice of treatment) and not radical surgery involving removal of important organs. Laparotomy refers to the surgical procedure of opening up the abdomen or an abdominal operation to examine the abdominal organs and aid in diagnosis. It does not include hysterectomy or bilateral salpingo-oophorectomy.

The case marked a significant ruling wherein, for the first time in India, it was ruled that, however broad consent might be for diagnostic procedures, it cannot be used for therapeutic surgery.

In Ram Bihari Lal v. Dr. J. N. Srivastava[57], the patient reported abdominal pain. After a preliminary examination, the doctor suspected appendicitis and insisted on an immediate operation. After obtaining due consent from the patient and her husband, the operation began. However, upon incision, it was found that her appendix was normal and not inflamed. The doctor then proceeded to remove her gall bladder as he found it to be blackish with stones, without the consent of the patient or her husband. Later, it was discovered that the kidney of the patient had been affected as a result of her extended use of chloroform anaesthesia on the patient, ultimately resulting in her death. The Court held the doctor liable for operating hurriedly on the patient without proper investigation and performing extra procedures without

[57] Ram Bihari Lal v Dr JN Srivastava, AIR 1985 MP 150

consent, particularly when it was observed that the gall bladder did not require immediate attention.

In Tabor v. Scobee,[58] a patient required an appendectomy. The surgeon discussed the procedure with her and obtained her consent. After anaesthesia was administered and the surgery began, the surgeon noted significant disease associated with the patient's fallopian tubes. This disease state was estimated by the surgeon to potentially result in serious harm or death if not treated within six months. Accordingly, he removed her fallopian tubes without obtaining informed consent from her. After being informed of this additional surgery, the patient sued the surgeon.

The Court held that the surgeon only had consent to perform the appendectomy and not for the removal of the fallopian tubes. Given that the surgeon had estimated six months to treat the condition, it did not classify as an emergency. By acting of his own accord, he robbed the patient of the opportunity to consider other treatment alternatives and make an informed decision.

Unauthorised extra-surgical actions highlight the critical importance of informed consent in medical procedures. Deviation from the agreed-upon procedure without explicit consent, except in genuine emergencies, constitutes a legal and ethical violation. Courts have consistently upheld the patient's right to autonomy, emphasising that consent for one procedure does not imply consent for additional or alternative interventions. The patient has the right to refuse treatment or opt for alternatives that they deem to be more suitable, and this right ought to be respected. These cases reinforce the necessity for medical practitioners to ensure clear communication, obtain informed consent and respect patient autonomy to avoid legal liability and uphold ethical medical practice.

EXCEPTION TO PATIENT'S CONSENT: PROXY OR SURROGATE CONSENT

There are select circumstances where the lack of the patient's consent is excused. When the patient is indisposed, proxy consent can be opted for. Proxy or surrogate consent refers to the consent given by an individual other than the patient for the medical procedure or treatment. Several parameters guide this principle, ensuring that only the patient's best interests are cared for. The National Medical Commission (NMC) recommends that in cases of major surgeries, the patient should execute an advanced directive nominating a legal representative who can

[58] Tabor v Scobee, 254 S W2d 474 (Ky 1951)

give consent on their behalf if required for further procedures during surgery when the patient is incapacitated.[59]

When patients cannot consent to medical treatment, healthcare professionals rely on an authorised surrogate for consent and decision-making. If patients have neither a court-appointed surrogate (guardian or conservator) nor a self-appointed surrogate (agent or proxy), healthcare professionals usually rely on the next of kin or even a close friend as the default surrogate decision maker. The typical order of priority is a spouse or domestic partner, an adult child, a parent, a sibling and then possibly other relatives or a close friend.[60]

All surrogates (whether appointed by the patient, by the Court or by default under state law) must follow the expressed wishes of the patient and to in the patient's best interests, taking into account the patient's personal values, goals of care and wishes to the extent known.[61]

Minors (individuals below the age of 18 years) are deemed incompetent[62] and are said not to have the legal capacity to give medical consent. Therefore, for non-emergency medical decisions affecting minors, medical care cannot proceed without a parent or guardian's consent. The parents' or guardians' decision can be overridden only if a court determines that the decision constitutes neglect or abuse of the child.[63]

In the case of Harish Kumar Khurana v. Joginder Singh,[64] the patient had undergone surgery for one of her kidneys and was advised to undergo surgery for the second one as well. While the patient was recovering from the first surgery, she was informed of the requirement for the second surgery. Consent was sought from her husband, who had been informed about the patient's high risk; all the while, the patient was kept in the loop. The Court ruled that the consent sought while keeping the patient in the loop signified valid consent.

In the case of Suchita Srivastava v. Chandigarh Administration,[65] an orphan woman, suffering from mild mental retardation and previously placed in a government-run welfare institution, was found pregnant, allegedly as a result of rape. While the High Court had ruled for

[59] NMC Regulations, guideline 5
[60] NMC Regulations, guideline 5
[61] ibid
[62] Zaki (n 51)
[63] Thaddeus Mason Pope, 'Consent and Surrogate Decision Making' (MSD Manual, October 2023) <https://www.msdmanuals.com/professional/special-subjects/medicolegal-issues/consent-and-surrogate-decision-making>
[64] Harish Kumar Khurana v Joginder Singh, (2021) 10 SCC 291
[65] Suchita Srivastava v Chandigarh Admn, (2009) 9 SCC 1

termination of the pregnancy, the woman had desired its continuation. The Supreme Court ruled that since the woman was not a minor, only suffered from a mild mental retardation and was not a mentally ill person, which was the criteria provided in the Medical Termination of Pregnancy Act,[66] the State's guardianship could not be automatically extended to make decisions regarding the termination of her pregnancy. The woman was permitted to continue her pregnancy per her wishes.

In Aarushi Dhasmana v. Union of India,[67] the Supreme Court affirmed that while the law has "always recognised the rights of parents with their wards/minors, but the first and foremost consideration of the Court is the welfare of the children, which overrides the views or opinions of the parents." Therefore, while parents have the right to consent for their child, if it is brought before the Court that their decision would result in harm or neglect to the minor, the Court may negate their consent and decide for the child themselves.

Proxy or surrogate consent plays a crucial role in medical decision-making when patients are unable to provide informed consent themselves. While guardians, family members or legally appointed surrogates are entrusted with making the patient's healthcare decisions, their authority is not absolute. It must align with the patient's best interests and, where possible, their known wishes. Courts have reinforced that surrogate decisions should prioritise patient welfare over personal or societal considerations. As seen in various cases, legal scrutiny ensures that such consent is exercised responsibly, protecting the rights and autonomy of those unable to consent independently.

EXCEPTION TO PATIENT'S CONSENT: MEDICAL EMERGENCIES

The more prominent example where consent may be bypassed is in the scenario of a medical emergency. If the medical practitioners observe that any further delay may result in significant injury or hurt to the patient, they may choose to act without the explicit consent of the patient. Such situations are commonly seen with victims of accidents, but may also occur during a surgery itself. However, it must be ensured that such a decision is taken only in cases of imminent risk to the patient where no suitable alternative is apparent.

[66] Medical Termination of Pregnancy Act 1971, s 3(4)(a)
[67] Aarushi Dhasmana v Union of India, (2013) 9 SCC 475

In the case of Jacovich v. Yocum,[68] a 17-year-old boy jumped from a moving train to reach the train track's embankment, but was caught on an iron step and dragged approximately 80 feet while protruding from behind the train car. Upon arriving at the hospital, he was found to have a crushed elbow joint and a two-to-three-inch scalp laceration, from which he was bleeding profusely. The patient was in significant pain and subsequently was sent to the operating room, where he was anaesthetized so that the physicians could treat the bleeding from the open wound. After being anesthetised, the patient was more easily examined and was found to require immediate arm amputation because of the danger the injury posed to his life. Based on this examination and conclusion, the physicians amputated the patient's arm. After the amputation, recovery and discharge, the boy and his parents brought suit against the treating physicians, alleging that the procedure was performed without their informed consent.

The Court held that any further delay on the part of the physicians would have placed the patient at risk of additional complications. Due to the immediate and imminent nature of the potential threat to the patient's life without emergency treatment, the Court ruled in favour of the defendant physicians.

In Rogers v. Sells,[69] a 14-year-old boy was injured when a car, in which he was riding with his parents, was involved in an accident. He was taken to the local Emergency Department, where a physician examined his right leg and found that it was "crushed and mangled; that the muscles, blood vessels, and nerves were torn and some of the nerves severed, and that the foot had no circulation." After the assessment, the examining surgeon amputated the boy's foot without the consent of his parents. The boy's parents sued the surgeon based on a lack of informed consent.

The Court held that based on the testimony presented, particularly of the boy who indicated he could "still feel and wiggle his toes" after the accident and before the amputation, in contradiction to the physician's testimony, the circumstances were not one of emergency or immediate or imminent harm to the boy. Hence, the Court ruled in favour of the parents and held that the doctor had violated his duty of obtaining informed consent.

In certain circumstances, it could be that the initial diagnosis may have been different from the actual complication, discovered only during the surgery. Courts have consistently held that

[68] Jacovich v Yocum, 237 NW 444 (Iowa 1931)
[69] Rogers v Sells, 178 Okla 103 (1936)

when such a complication demands immediate intervention, moving forward without the patient or their proxy's consent does not incur liability.

In S.K. Jhunjhunwala v. Dhanwanti Kaur,[70] the doctor advised the patient, on an examination of her symptoms, to undergo laparoscopic surgery for her gall bladder. However, during the surgery, the doctor discovered swelling, inflammation and adhesion in her gall bladder. He informed the patient's husband of the same and suggested general surgery to remove the gall bladder, which the husband consented to. The patient later alleged that she had never consented to the general surgery and, as a result of the doctor's negligence during the surgery, developed subsequent ailments for which she had to undergo another operation at a different hospital.

The Court ruled in favour of the doctor, observing that the consent form signed by the patient included a clause that empowered the doctor to perform such additional operation or procedure as he may consider necessary in the event of any emergency or if any anticipated condition is discovered during the operation. Moreover, the abnormalities made it impossible for the doctor and his team to continue with the laparoscopy of the gall bladder. Given that the substitute surgery was for the same organ as the original surgery, the Court ruled that there was no need for another consent form for the conventional surgery in light of the authorisation from the requisite clause.

In the US case of Barnett v. Bachrach,[71] a pregnant patient reported significant abdominal pain. Upon emergency examination, she was found to have symptoms of an ectopic pregnancy. The patient provided informed consent for its removal. After induction and anaesthesia were performed on the patient, the surgeon discovered that the patient was suffering from acute appendicitis. The surgeon, upon further examination, concluded that the appendix should be removed immediately due to the condition of the tissue and potential risks associated with her condition. He performed an appendectomy without informed consent from the patient. The surgery was successful, and the patient experienced an uneventful recovery.

However, upon discharge, the patient refused to pay for her medical care services, indicating that she had only granted informed consent for surgery for an ectopic pregnancy, not an appendectomy. Nevertheless, the Court ruled against the patient and noted that the severity and seriousness of the patient's condition obviated the need to re-obtain informed consent.

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[70] SK Jhunjhunwala v Dhanwanti Kaur, (2019) 2 SCC 282
[71] Barnett v Bachrach, 34 A 2d 626 (D C App 1943)

However, as observed in Ram Bihari Lal v. Dr. J. N. Srivastava,[72] where a situation is not one of imminent danger, the doctor is not protected under the exception of medical emergency. In this case, the procedure for the gall bladder could have been postponed by a few days with no harm incurred, as was admitted by the doctor himself, and hence, the doctor's decision to remove the gall bladder without the patient's consent invited liability.

The exception of medical emergencies allows doctors to act without prior consent when immediate intervention is necessary to prevent serious harm or death. However, courts have consistently emphasised that this exception applies strictly to cases of imminent risk where delays could endanger the patient's life. As seen in various rulings, when the urgency of a procedure is evident, doctors are protected from liability, but if an emergency is not established, performing an unauthorised procedure can lead to legal consequences. This reinforces the principle that patient autonomy remains paramount, except in genuine life-threatening situations where timely medical action is essential.

GHOST SURGERY: DEFINITION AND LEGAL ISSUES

Ghost surgery occurs when the original surgeon substitutes someone else to operate, without the consent of the patient. It may be defined as when a physician assistant, a surgical assistant, a registered nurse first assistant, a resident or another surgeon assists in or performs an operative or other invasive procedure without the patient's knowledge, regardless of whether the surgeon who obtained the consent was scrubbed in or not.[73] The phrase 'ghost surgeon' is not a legally or medically defined term, but typically refers to the surgeon who stepped in to perform the procedure instead of the originally selected surgeon.[74]

According to the Regulations by the NMC, after having accepted a case, the medical professional must not neglect the patient nor withdraw from the case without giving adequate notice to the patient and their family. If a change of doctor is needed (for example, the patient needs a procedure done by another doctor), consent should be obtained from the patient themselves or the guardian.[75] Further, the NMC also provides that doctors should abide by a code of ethics, as per which, they should be respectful of the patient's rights and opinion,

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[72] Ram Bihari Lal (n 57)
[73] Debra Dunn, 'Ghost Surgery: A Frank Look at the Issue and How to Address It' (AORN Journal, 27 November 2015) <https://doi.org/10.1016/j.aorn.2015.10.003>
[74] 'What is a Ghost Surgery?' (Merson Law, 25 June 2023) <https://mersonlaw.com/ghost-surgery/>
[75] NMC Regulations, reg 26

communicate clearly with them and be honest and transparent in all professional interactions.[76] This communication and transparency also extends to informing the patient of a change in his operating surgeon.

The practice of not obtaining consent and thereafter performing ghost surgery denies patients important information, eliminates their ability to provide informed consent and represents a crucial ethical issue that must be dealt with.

Historically, ghost surgery referred to a medical practitioner's system of signing records, sending bills for operations and assisting patients following their procedures, leading patients to believe that the practitioner completed their surgeries himself when, in reality, the procedures were performed by travelling surgeons the patients had never met. Over time, this practice evolved into something just as dangerous, with more modern legal and ethical implications, often resulting in surgeons collecting fees for procedures they did not perform.[77]

It is unclear how often such "ghost surgeries" occur because they are not tracked or studied. Often, they are never even detected. Nevertheless, lawsuits provide a glimpse into the accusations of unhappy patients who had bad outcomes, started to look into what went wrong and learned they were mistaken about which doctor performed the procedure.[78]

There are very few statistics that confirm the extent of this practice. In 1996, a US study found that 50% to 85% of operations were carried out by medical residents instead of the surgeons whom patients had carefully selected for their procedures. Ghost surgeries often go unnoticed, assuming they do not result in injury to the patient. Nevertheless, patients are increasingly concerned about being the victims of ghost surgeries. Some patients contend that they would not agree to a procedure if they knew a resident or another surgeon they had never met would perform it.[79]

[76] NMC Regulations, guideline 3

[77] Madelina Brown, 'Hauntings in the Operating Room: Dissecting the Legal and Ethical Implications of Ghost Surgeries' (University of Cincinnati Law Review, 17 January 2024) <https://uclawreview.org/2024/01/17/hauntings-in-the-operating-room-dissecting-the-legal-and-ethical-implications-of-ghost-surgeries/>

[78] Deborah L Shelton, ''Ghost Surgery': When your surgeon isn't the one you expected' (The Seattle Times, 29 September 2012) <https://www.seattletimes.com/seattle-news/health/ghost-surgery-when-your-surgeon-isnt-the-one-you-expected/>

[79] Brown (n 77)

REASONS FOR GHOST SURGERY

Today, ghost surgeries occur primarily in one of two scenarios (that may overlap in practice):[80]

- A surgeon booked more than one surgery for the same time, requiring other surgeons or medical providers to perform the procedures, in part or their entirety (i.e., "concurrent surgeries"); or
- A medical resident performs the surgery as a training opportunity.

There may be other reasons, such as if there is a medical emergency involving the surgeon, but concurrent surgeries and resident training remain the most common.

The American College of Surgeons (ACS) guidelines for their fellows clearly state the surgeon's responsibility: "The patient's surgeon should be in the operating suite or the immediate vicinity for the entire surgical procedure." "The surgeon may delegate part of the operation to associates or residents under his or her supervision, because modern surgery is often a team effort."[81]

The guidelines further say, "It is proper to delegate the performance of part of a given operation to assistants, provided the surgeon is an active participant throughout the key components of the operation. The overriding goal is the assurance of patient safety." In the operating room policies manual issued by the University of New Mexico Hospital (UNMH), the key portion of a procedure is defined as all periods of more than minimal risk ("the determination of which will depend on the particular patient and the skills/experience of the residents being supervised").[82]

Although studies show that the involvement of surgical residents in operations generally does not negatively impact health outcomes, disclosure regarding a resident's participation in the procedure should be standard practice. As such, a surgeon who fails to disclose such crucial information to a patient should be subject to a claim of lack of informed consent.[83]

During concurrent surgeries, two or more complex procedures are often handled in stages. The surgeon participates in one phase of a patient's surgery and then moves on to another patient.

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[80] Stanley M Shapshay and Gerald B Healy, 'The ethics of running multiple operating rooms simultaneously: Is this Ghost surgery?' (2016) 126(9) The Laryngoscope 1959 <https://doi.org/10.1002/lary.26022>
[81] ibid
[82] Shapshay, Healy (n 80)
[83] Brown (n 77)

They are hardly rare and are allowed under certain conditions at many prestigious hospitals where they are viewed as an efficient way to meet patient needs, especially when few in-demand specialists are available. Allowing surgeons to book multiple surgeries at the same time may be part of a medical institution's business model. Some medical systems use incentives that increase a doctor's pay if they generate more profit, thus encouraging the double-booking of surgeries. However, they are limited or banned in many other hospitals due to their potential to harm patients.[84]

Concurrent surgeries may lead to ghost surgeries when a single doctor, who is scheduled for more than one surgery at a time, delegates his surgeries to other doctors or unsupervised residents while he is operating on a single patient. In such a scenario, while it may appear to the patient that he is being operated on by the doctor they selected, the situation may be entirely different.

Running multiple simultaneous operating rooms brings up several major issues:[85]

- Failure to provide adequate informed consent to the patient.
- Exposing patients to the potential of increased complications or poor surgical outcomes by allowing residents in training or fellows to do unsupervised surgery.
- Fraud in billing for services not personally rendered.
- Failure to adequately educate trainees.

Failure to provide truthful information to a patient breaches a sacred contract between patients and their physicians. There is not much published information on the incidence of a single surgeon running multiple simultaneous operating rooms; however, it is common knowledge that this practice is widespread. The most likely motive for this is profit for both the surgeon and the hospital.[86]

CASE STUDIES OF GHOST SURGERY FROM AROUND THE WORLD

While instances of ghost surgery from India are less known, they are particularly gaining prominence in other countries, with patients raising their voices against this practice. It is,

[84] Shapshay, Healy (n 80)
[85] Ibid
[86] Ibid

hence, necessary to be adequately informed on this issue and be armed with appropriate protective measures, on the part of both the doctors and the patients.

One of the most prominent examples is the case of the 11-year-old boy from Cincinnati, Jack Steiger, who suffers from a rare neurological disease known as chorea. After several years of failing to treat it, his family met with a famous neurosurgeon from Minnesota, who implanted a deep brain stimulator in his brain. Slowly, his condition began to improve. The stimulator required its batteries to be changed every few years by surgery, which the neurosurgeon had conducted more than once. However, Jack's most recent surgery was not conducted by the neurosurgeon but rather by a second-year resident. Following the surgery, Jack's condition deteriorated rapidly and he developed multiple issues and health concerns, including pain, fever, swelling and reddening of the surgical sites, followed by infection of his head when the batteries were eventually removed.

Despite these facts, it was later discovered that the consent form signed by the family did contain a clause allowing residents to change the batteries, negating any legal action in that direction that the family could have pursued.[87] However, it remains a troubling example of how patients and their families can be unaware of who is performing a procedure, raising ethical concerns about transparency in medical practice.

In another case, Denyse Richter of New Hampshire filed a medical malpractice case after her heart was severely damaged in a cardiac operation. She had sought out a renowned cardiologist, but instead, her procedure was performed by his less experienced associate as he was engaged in another operation, which resulted in Richter requiring a pacemaker.[88]

Doctors and surgeons themselves disapprove of this practice. In the case of Goldberg v. Rush Univ. Med. Ctr.,[89] an orthopaedic surgeon from Chicago, filed a suit accusing the Medical Centre and a group of fellow surgeons of billing Medicare Insurance for operations conducted by unsupervised medical residents. As part of the suit, patients reported that the supervising physician never even entered the operating theatre while the resident performed the surgery.[90]

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[87] Lindsay Oliver, 'Family Claims Ghost Surgery Caused Son's Complications, Warns Others How to Prevent It' (Spectrum News 10 October 2020) <https://spectrumnews1.com/oh/columbus/news/2020/10/09/family-says-son-suffered-complications-from--ghost-surgery>
[88] Shelton (n 78)
[89] Goldberg v Rush Univ Med Ctr, 929 F Supp 2d 807 2004
[90] 'Whistleblower lawsuit accuses six surgeons of Medicare fraud' (Fierce Healthcare 12 July 2010) <https://www.fiercehealthcare.com/healthcare/whistleblower-lawsuit-accuses-six-surgeons-medicare-fraud>

Dr. Julia Hallisy, a dentist based in San Francisco, discovered in 1998, on reviewing her daughter's medical records, that the name of the surgeon she had expected to perform a biopsy was not in the operative notes but instead was the name of two medical residents. Nonetheless, the surgeon had presented himself as the one to perform the biopsy. Although her daughter was not harmed, the family felt manipulated and filed a complaint with the California Medical Board.[91]

In 2012, Mary Anna Bart of Illinois underwent a procedure for the removal of her recurrent kidney stones. She ensured her consent form laid out her wishes: for the doctor, a renowned urologist, to perform the procedure himself. However, she alleged that the doctor never scrubbed in for the procedure, despite his oral promise and signature on the form. Instead, one of his urology fellows did the operation.

Complications from the surgery required Bart to be resuscitated twice[92], and following her operation, she developed a series of dire medical issues, including respiratory failure, hypoxemia, aspiration pneumonia and septic shock, along with the mental and emotional strain as a result of the whole situation.[93]

RECOMMENDATIONS

To improve transparency, protect patient rights in surgical procedures, particularly in teaching hospitals, as well as open communication between doctors and patients, the following recommendations should be implemented:

- Patients must be properly informed of the procedure they are to undergo, including all risks and benefits, and the consent form should represent the same. They should also be informed of the contents of the consent form to ensure complete communication, clarity and transparency.
- Patients should request the consent form well in advance and carefully review its contents. Before signing, they should ensure the surgeon's name is explicitly mentioned on the consent form.

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[91] Shelton (n 78)
[92] ibid
[93] 'David A Axelrod & Associates Files Complaint for Battery and Fraud Against Preeminent Urologist, Robert B Nadler, M D and Northwestern Memorial Hospital' (PR Newswire 4 October 2012) <https://www.prnewswire.com/news-releases/david-a-axelrod--associates-files-complaint-for-battery-and-fraud-against-preeminent-urologist-robert-b-nadler-md-and-northwestern-memorial-hospital-172704981.html>

- Patients must be notified of any change in their doctors, as well as the presence and participation of residents.
- The attending surgeon must clarify their level of supervision and the extent of delegation during the operation.
- Patients should be informed about institutional policies regarding the involvement of students, residents and trainees in surgeries.
- Any decisions and procedures undertaken during an emergency must be documented, as well as the observations and reasoning behind them.
- Regular inspections should be conducted to prevent circumvention of the law.

Implementing these recommendations would foster trust, reduce instances of ghost surgery and ensure that patients are fully informed and empowered in their medical decisions.

CONCLUSION

Consent forms a fundamental aspect of a doctor-patient relationship, and its breach may incur liability under the legal as well as ethical frameworks. The foundational tenets of medical jurisprudence state that an individual has the right to make autonomous decisions about their own body, including the choice of treatment and the identity of the doctor. Notwithstanding, in select circumstances, particularly in cases of medical emergencies, medical practitioners are permitted to move forward sans consent in the best interest of the patient, but such an exception is heavily regulated to ensure that a patient’s rights and health are not injured as a result of misuse. While the issue of ghost injury needs to be addressed better, the current framework can be easily modified to reduce its incidence. This will safeguard not only patient autonomy but also reaffirm and uphold the integrity of the medical practice within the bounds of law.