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RESEARCH ARTICLE

COMPARATIVE EVALUATION OF KNOWLEDGE ABOUT CAPACITY AND CONSENT AMONGST DOCTORS WORKING IN PRIVATE AND GOVERNMENT SECTORS IN INDIA

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Abstract

Although the Indian definition of the term 'consent' traces its origin to the New York Civil Code, as per Section 13 of the Indian Contract Act, 1872 "two or more persons are said to consent when they agree upon the same thing in the same sense". [1]. The language of consent, as some agree, is more judicial or expository than legislative. Section 11 of the Indian Contract Act, 1872 States that "every person is competent to contract who is of the age of majority according to the law to which is subject, and who is of sound mind and is not disqualified by any law to which he is subject." [1]. However capacity to consent must be distinguished from authority to consent. This study aims at observing and assessing the knowledge of doctors, regarding the aspects of consent in certain situations, that they mostly come across, while practising in various clinical and non clinical departments in private and government institutions across India. It is an observational, questionnaire based study that has been conducted in Peerless Hospitex Hospital and Dr B.K. Roy Research Institute over a period of 24 months (November 2017- October 2019) after obtaining ethical clearance. It has been observed that there is no significant difference in knowledge regarding consent-taking practices amongst doctors across varied age groups [p value of 0.5(>0.05)]. However there is significant difference in knowledge regarding capacity to give consent across varied age groups of doctors [p value of 0.028(<0.05)]. It is also noted that years of work experience does not significantly affect knowledge regarding consent-taking [p value of 0.554(>0.05)] but, does affect knowledge regarding capacity to consent [p value of 0.010(<0.05)]. Interestingly it has also been found that doctors practising in government and private healthcare institutions have significant difference in knowledge regarding capacity to consent [p value<0.05] but have almost similar knowledge regarding consent itself [p value of 0.152(>0.05)]. Number of working hours (full/part time) does not have any significant effect on knowledge amongst doctors. It has also been observed that doctors working across various disciplines, irrespective of government or private institutions, have significant difference in knowledge regarding consent and capacity to consent, with the

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maximum knowledge possessed the discipline of Emergency Medicine(mean value of 4.52 and 3.08 respectively).

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..... **Introduction:-**

The word 'Consent' comes from the Latin words con(meaning together,with) and sentire(meaning feel).Philosophically speaking, consent is an agreement of feelings.

The law defines consent as “a voluntary yielding to what another proposes or desires; agreement, approval, or permission regarding some act or purpose, esp. given voluntarily by a competent person; legally effective assent.”[2].In basic terms, consent is the understanding that the parties entering into a contract have between themselves. This understanding (or consent) is important to determine the validity of the contract.

In current times, medical policies deem consent itself as a form of contract.[3]. It's like an off-and-on switch which means, consent is either given or not given, with no gray areas in-between.Since treating consent as a contract freezes patient autonomy in time,it(patient autonomy)is considered to be an important principle in medical ethics. Any patient seeking medical consultation has full right over his/her body and can consent to any form of medical treatment without being vetoed by someone else. Therefore valid consent is necessary before any medical treatment.

The idea of informed consent had been conceived thousands of years ago,as is evident by documents retrieved from early Greek,Roman and Egyptian civilisations.In fact,it has been found that Plato would discuss the disease,it's anticipated course of treatment,the risks and benefits of it,with his patients.[4]. But with time, this concept gave way to the Hippocratic physician,who would be more morally bound to his patients than legally. This in due course,gave rise to medical paternalism thus slowly and steadily strangulating the idea of patient autonomy.

With the adoption of Nuremberg Code in 1946, it was declared that science must not consider human beings as mere tools and thus,the tables turned again in the world history.

Looking back into the past of Indian medical ethics,it is evident that the principle of patient autonomy has generally been ignored or partially accepted.

However, with the introduction of Consumer Protection Act,both the doctors and patients have become more aware of their responsibilities and rights, respectively.[5]. But like darkness under light, this increased patient awareness has created more panic and confusion and is making the medical profession more defensive. The situation has been further complicated by the fact that a significant percentage of Indian population is illiterate and hence,does not possess enough intellectual skill to comprehend the proposed line of treatment. In times such as this,communication forms the heart and soul of consent. An effective communication between a doctor and his/her patient regarding the nature of disease and it's treatment,may help in devising the ideal consent and thus in turn,help to abate and avert many medicolegal cases.

The United States of America is considered to be the country of origin of informed consent. The process started in early eighteenth century and after decades of evolution became what we know of it today.[4].

India and America: A difference in perspectives:

In India and other commonwealth countries,the courts of law follow a 'doctor-oriented' approach, rather than a 'patient-oriented' approach that is being practiced in American and Canadian courts.[5].

This means that patient autonomy has gained an upper hand in countries like America and Canada. However,that the courts of law all over the world has universally restricted active euthanasia,stands as a starkly contrast example to this concept.

Talking about the Indian scenario regarding practice of patient autonomy,a review of medicolegal case laws in India shows that the Indian courts had had not deemed the doctor guilty of tort or battery in certain cases where there had been omission of facts(willing/unwilling) regarding a disease,its treatment and possible adverse effects of the treatment [6], or where there had been execution of a certain treatment that the doctor had decided to be of

importance, without prior consent from the patient or by obtaining consent for the same from an individual related to the patient, who, in terms of the medical law, does not have the capacity to consent.

However similar cases in American and Canadian courts had had a different approach and course.

In a nutshell, it may be concluded that American courts attach more importance to a 'reasonable patient' than to a 'reasonable doctor'. As the courts in India have started adopting the approach of American courts of law, the medical professional's paranoia regarding medicolegal cases have taken a northward course. Doctors have started scurrying to prepare various "legally foolproof" consent forms without being aware of its technicalities. Furthermore, abuse of this concept of consent by a malicious few, has set the doctors wrangling for the 'ideal consent'.

Hence it is important to determine the clinician's knowledge regarding Consent and Capacity to Consent. It is also important to determine at which level of medical career (student, intern, house staff, resident, registrar, consultant) should this knowledge be imparted so that it can be maximally beneficial to the clinicians. There are also no present means of objectively bringing at par, the doctors' knowledge regarding current medical laws. No studies have been done till date delving into these aspects. This study will strive to serve as a page mark to the many existing questions regarding evolving standards of medical lawsuits in India and might help the future researchers to throw light into the crevices of the Indian doctor's paranoia, which in turn will help them to drop their overtly defensive approach to the profession and develop a more humane one.

Review of Literature:

Consent may be used as an affirmative defence against assault, battery and other related torts.[2].

From a medicolegal perspective, consent may be broadly divided into two categories— the philosophical and the factual. Or as it is more commonly known, the implied consent and the expressed consent. Informed consent may be implied or expressed. An expressed consent is one which is 'clearly and unmistakably stated' whereas the consent 'inferred from another's conduct rather than his/her direct expression, or consent that is imputed as a result of circumstances that arise' is an implied consent.[2]. Informed consent is a person's agreement to allow something to happen, made with full knowledge of the risks involved and the alternatives. It may be either stated or imputed.

It may be interestingly noted that while obtaining consent for most medical practices/intervention is a must now, it is the medical practice/intervention itself that determines the type of consent to be obtained. For example, the consent for a procedure like a neurosurgery or a Caesarean section must be a written and informed consent, while the consent to examine a patient may be an implied one.[7].

Gupta et al has stated in his article that there are three main principles of an informed consent, likely, voluntarism, decision-making capacity and information disclosure .[8].

Of the three principles, voluntarism is a relatively abstract principle with a philosophical angle to it. Voluntarism is the ability of an individual to act as per his/her choice. It is an individual-dependent, intuitive aspect. In 2002, Roberts had studied a model to demonstrate the main factors influencing voluntarism.[9]. It was found that voluntarism is mostly affected by individual parameters (like one's developmental history and past and present medical history), social parameters (like traditions, religious beliefs) and external parameters (like the local law).

Decision-making capacity in healthcare must be distinguished from competency determination. Whereas the latter is done by the court, the former is done by a clinician. And since the clinician is legally and morally bound to his/her patient and it is not possible to legally declare a patient competent before initiating treatment, tools have been devised to assess a patient's decision making capacity. In a review of these tools, it has been established that there are four important criteria's to determine the decision-making capacity of a patient. They are understanding, appreciation, reasoning and expression of a choice.[10].

Information disclosure is one of the sensitive aspects of an informed consent. Effective communication forms the foundation of how a patient perceives the information that is being put in front of him/her by the treating doctor.[5]. With the recent shift of focus from the 'reasonable' doctor to the 'reasonable' patient in healthcare industry, it is important that the patient understands what the doctor is trying to convey and vice versa in order to avoid

unnecessary litigations. However, it has been observed that the perception of the information disclosed is often influenced by factors like religious beliefs, societal laws etc.

In a study done by Hammani et al it has been seen that the patient is more interested to know about the benefits of a certain treatment than knowing about the ailment, the available treatment alternatives with risks and benefits of each. However, a patient with a previous history of a procedure is more interested in information disclosure than a patient without. [11].

In the case of *Canterbury vs Spence*, the court held the doctor guilty of not disclosing all the risks of a lumbar laminectomy (like loss of bladder functions, lower limb paralysis) to the patient, although, the course of events, as recorded, states that whatever physical disability the patient suffered post surgery was after he had had a fall from bed during his hospital stay and not directly after the surgery in question. [12].

Having discussed so, it is important to determine the extent of knowledge possessed by medical practitioners in India, regarding consent and capacity. India, with its diverse disciplines of medicine, like Homeopathy, Ayurveda, Yoga, Unani etc in which the therapeutic procedures are rarely standardised, has always lagged in imparting adequate knowledge regarding consent to the sophomores of medicine. [13-15, 18].

A study done by Yousuf RM et al in India concluded that it is the doctor's opinion that is considered to be superior than the patient's own regarding clinical decision-making, although the awareness regarding informed consent was highly prevalent. [13]. The study highlighted the lack of voluntarism, which is one of the important aspects of an informed consent. It also reflected the need to change the medical practitioner's attitude towards obtaining a consent and in the process of it, acknowledge the patient's autonomy.

Another similarly structured study done by VV Gupta et al in India, also suggested an imbalanced knowledge amongst doctors regarding informed consent. [14].

However none of the authors in the abovementioned studies had evaluated the knowledge of doctors regarding capacity to consent.

Another qualitative study done by Shuba Kumar et al suggested that the perception of informed consent varied widely amongst the patients. While most found the information provided to be confusing, a few stated that the information provided was inadequate or unrelatable. [15].

Not just in India, but also in the UK, studies have found that doctors do have inadequate knowledge regarding capacity and that greater training is needed at both undergraduate and postgraduate levels of medical curriculum. [16]

In Australia, a study done by Scott Lamont et al also concluded that there is prevalence of confusion amongst the healthcare professionals regarding the legalities of decision-making capacity and consent to treatment and that structured educational tools are the need of the hour. [17].

A questionnaire-based survey conducted in India by Ashish Jain et al had attempted to assess the doctors' approach to an informed consent but concluded that certain aspects were overlooked by the doctors while obtaining an informed consent in their day-to-day practice. [18].

A brief review of few case laws in India might help to quantify the difficulty of this inadequacy in knowledge regarding consent and capacity.

In the case of *Ram Bihari Lal vs Dr. J.N. Shrivastava*, it was found that the doctor had obtained consent from patient's husband for removing her appendix. [19]. However during the course of the operation he found that it was the gall bladder that was inflamed and he removed it. The doctor said that he could not obtain a consent for doing the operation on gall bladder from the patient as she was under anaesthesia and he also did not think it necessary to obtain the same from her husband as he had already consented for one surgery. The doctor also stated that he did whatever had to be done in the best interest of the patient.

This case clearly depicts the aspects of medical paternalism, jeopardized patient autonomy and the lack of knowledge about consent and capacity amongst medical professionals in India.

In the case of Paramanand Katara vs Union of India, the Supreme Court of India stated that the doctor must attend to every patient with life threatening emergencies and impart medical care to the best of his skill and knowledge.[20]. However the court had failed to explore or lay down the scope of this “skill”.

In another case of Dr T.T. Thomas vs Smt. Elisa, the court found the doctor negligent for not operating on a patient of perforated appendix with generalised peritonitis. The doctor pleaded that he could not proceed with the operation as he was unable to obtain a consent for the same from the patient or his relatives. This case also clearly depicts the existing lacunae in knowledge regarding consent and capacity amongst doctors in India. [21].

In a landmark judgement of the Supreme Court of India in case of Samira Kohli vs Dr Prabha Manchanda , the Court laid that consent obtained from a patient for conducting an invasive diagnostic procedure cannot be used for conducting another invasive therapeutic procedure, until and unless it can be proved with substantial worth that the therapeutic procedure was absolutely necessary for saving the life of the patient.[22].

The lack of knowledge of doctors regarding the importance of obtaining a valid informed consent is prevalent in Indian case scenarios even in recent times. As laid down in the case of Sou.Sanghamitra@ Sandhya vs Dr S.Gadekar, the Court found the doctor negligent of full disclosure of his planned course of action and hence, was held liable for the same.[23].

In the case of Qamar Jahan vs Dr Nisar Ahmed Tyagi, it was seen that although there was inability on the part of certain doctors to distinguish between acute cholecystitis and acute fulminant hepatitis, the Court did not hold the doctors liable for any omission of information, which proves that the doctors attending to Mr Jahan had always briefed the patient’s relatives regarding his clinical condition and had also obtained valid consent at all necessary crossroads.[24].

Then there exists the question of capacity to consent as in the case of Fortis Escort Hospital vs Amarjeet Singh. In this case it was seen that the patient was admitted to the aforesaid hospital and the doctor had explained the need of an urgent life saving surgery including the high risk nature of the surgery and the high mortality rate associated with it. But since the patient’s son was not present at the scenario, no consent for the same could be obtained and hence, there was delay in carrying out the surgery.[25].

In the case of Ramesh Chandra Agrawal vs Regency Hospital Ltd., the patient was operated upon for Pott’s spine and later on developed loss of bladder control and loss of power of both legs. The patient filed a case alleging that the operation was not needed and demanded compensation for his physical disability. This again reflects the inadequacy in knowledge amongst doctors regarding a graded approach of counselling and obtaining informed written consent.[26].

From the above instances the following lacunae in the knowledge of the doctors regarding consent and capacity may be noted:

1. when to obtain a consent and who to obtain it from
2. term/validity of a consent
3. effective communication with patient and/or patient companions while obtaining consent
4. the best form of consent while treating a patient
5. assessing and evaluating patient’s understanding regarding the disease and the proposed treatment before a patient signs a consent form

Aim:

With the increasing number of medicolegal cases in India, doctors’ attitude towards the profession is becoming more and more defensive. Culture of prescribing unnecessary tests or refusing to treat a patient with a more complicated disease, is on the rise. [28].

Furthermore, Dr Ashish Kr Jha et al has studied that two-thirds of the 42.7 million annually reported adverse events in medical care occurs in developing and transitional countries.[29].

These scenarios combined, has led to a considerable rise in medicolegal cases as per the Supreme Court of India.

Hence, it is of utmost importance that the doctors hold their ground while treating patients and be not intimidated unnecessarily. Only then can doctors live up to the true spirit of the profession. And to achieve this, it is important for them to know the intricate legalities associated with the decisions they make.

Although this study is limited by time and resources, an attempt has been made to qualitatively measure the knowledge existing among doctors regarding an important medicolegal aspect, i.e. capacity and consent, so that policies and protocols may be devised in near future to educate them about how to evade from being sued unnecessarily.

Objectives:-

The following points have been explored in this comparative study:

1. whether there is any difference in knowledge regarding capacity and consent amongst doctors practising in private and government institutions in the country
2. whether there is any inter-disciplinary disparity in knowledge of doctors regarding capacity and consent
3. whether there is adequate knowledge regarding ideal consent-taking practices and capacity to consent amongst doctors working in Emergency departments in India
4. whether the knowledge regarding capacity and consent varies with years of practice and professional designation
5. whether the knowledge on capacity and consent is limited to any particular geographical location in the country
6. whether there is any difference in knowledge regarding capacity and consent between male and female doctors
7. knowledge of doctors regarding when to obtain a consent
8. knowledge of doctors regarding the legally valid age of consenting

Materials and Methods:-

A questionnaire based method of data collection has been adopted as it is cheap and reaches out to a larger number of people in relatively small amount of time. Another advantage is that this allows a fixed sequence of questioning. Questionnaire based surveys also tend to address the subtle parameters in certain studies, which are otherwise difficult to obtain.[30].

Study Design:

An observational, questionnaire based survey.

Study Site:

The study is based out of Peerless Hospitex Hospital and Research Centre. The questionnaire had been circulated online, as household drop-offs and as hard copies in a snowball fashion.

Study Duration:

The study has been conducted over a period of 24 months [November 2017- October 2019].

Study Population:

This study applies to all doctors currently practising in India, who meet the inclusion criteria. Since the exact number of doctors currently practising in India is not known, so a random population size of 20,000 had been adopted and the sample size was calculated using Raosoft sample size calculator.
[<http://www.raosoft.com/samplesize.html>]

The following parameters were administered:

Population size:

20,000

Confidence level:

95%

Margin of error:

5%

Response Distribution:

50%

The sample size was calculated to be 377, rounded off as 380.

The sample size [n] and Margin of error [E] are given by:-

$$x = Z[c/100]2r[100-r]$$

$$n = N x / [(N-1)E^2 + x]$$

$$E = \text{Sqrt}[(N - n)x/n(N-1)]$$

where N is the population size, r is the fraction of responses that are of interest, and $Z[c/100]$ is the critical value for the confidence level c.

Inclusion criteria:

1. All doctors practising allopathic medicine in India.
2. All allopathic doctors who have successfully completed MBBS curriculum and one year of compulsory rotatory internship.
3. All allopathic doctors with a valid registration number [MCI/ State].

Exclusion criteria:

1. Any non-allopathic doctor.
2. Any doctor without a valid registration number.

Study Methodology:-

Out of the 380 samples, 17 online questionnaires were sent back incompletely answered. 4 hard copies were returned unanswered. Another 9 samples were disqualified as the respondents were interns. The final data comprised of 350 samples. All respondents were coded and data was recorded on an excel sheet which was then sent to the statistician for analysis.

Designing the questionnaire:-

The question set was first drafted from that of a previous similar study done in this hospital. It was then taken to the HOD, Dr Indraneel Dasgupta for further refinement.

A question comprising of a simple mathematical calculation was put amongst the questionnaire set to ensure that the respondents have actively participated in answering the questions.

Prior to sending out the final questionnaire, a pilot study was performed in Peerless Hospital amongst all the doctors working in the hospital to assess their understanding of the questions and the consistency in their answers. The questionnaire was handed over as hard copies to each doctor twice in a month's interval and the answers were compared with the help of a statistician. No significant difference in individual's answering pattern was noted.

Circulating the questionnaire was done in two ways. First through online portal www.surveymonkey.com and Second, as hard copies which were handed individually and then in snowballing method.

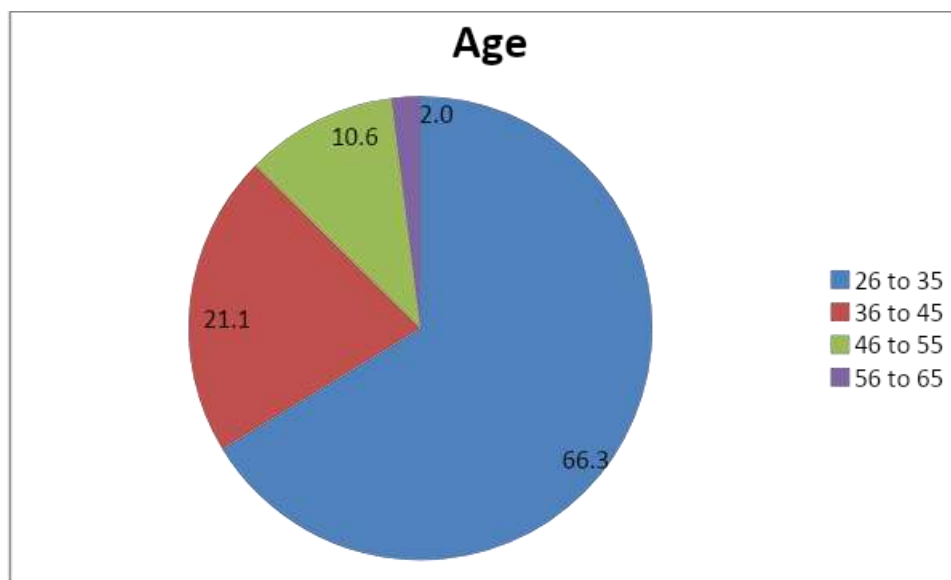
The online questionnaire was circulated twice at a gap of 3 weeks to ensure successful response. The hard copies were collected personally from the respondents.

Statistical analysis of the encoded data was done with the help of a statistician.

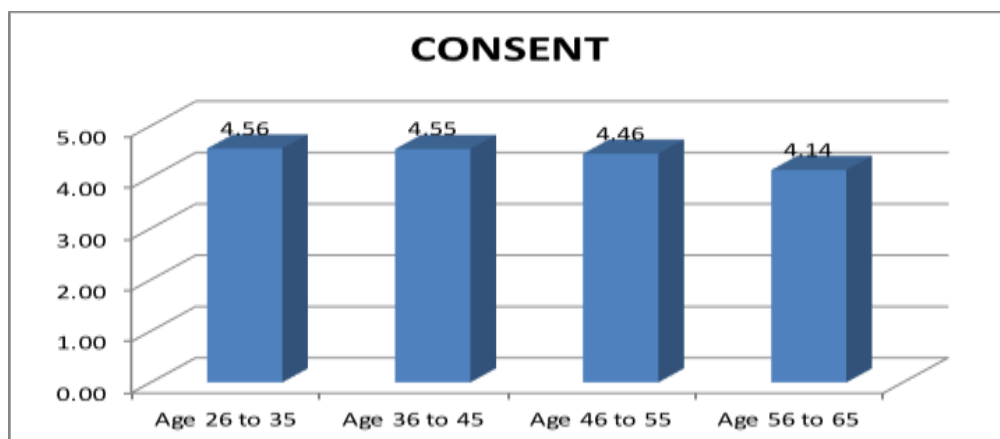
Results and Discussion:-**1. What is your age?**

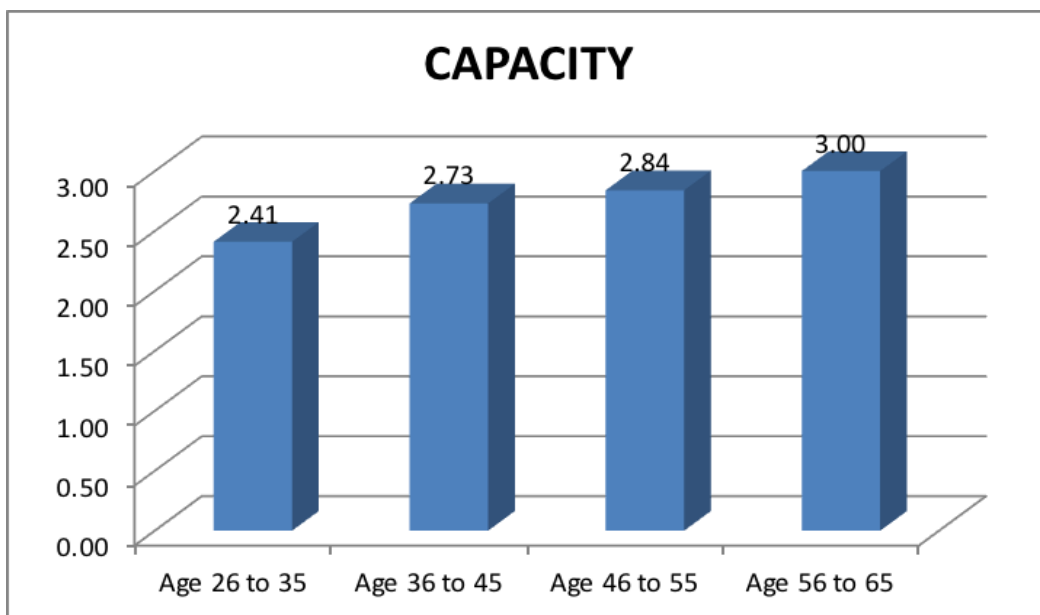
What is your age?	Frequency	Percent
26 to 35	232	66.3

36 to 45	74	21.1
46 to 55	37	10.6
56 to 65	7	2.0
Total	350	100.0



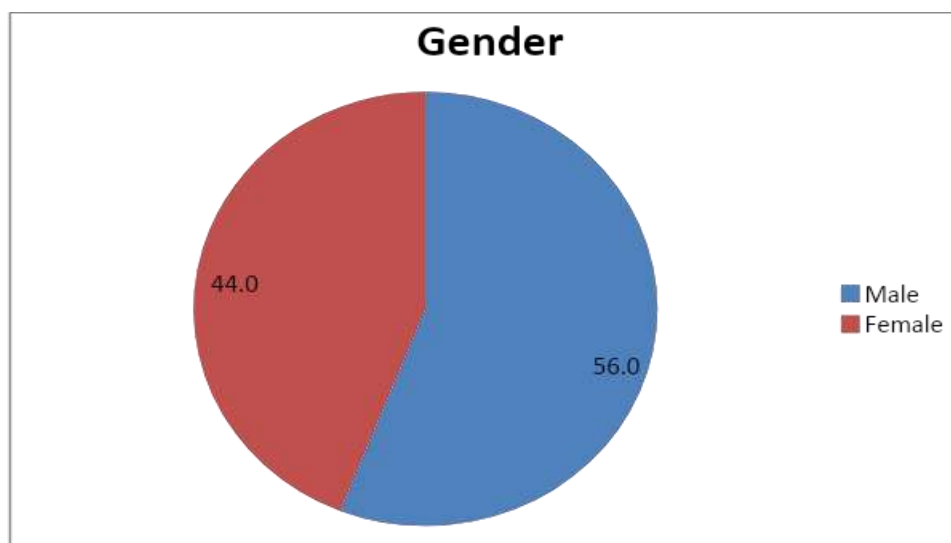
What is your age?		CONSENT	CAPACITY
26 to 35	Mean	4.56	2.41
	Median	5.00	2.00
	Std. Deviation	0.92	1.12
36 to 45	Mean	4.55	2.73
	Median	5.00	3.00
	Std. Deviation	0.86	1.02
46 to 55	Mean	4.46	2.84
	Median	5.00	3.00
	Std. Deviation	0.80	0.87
56 to 65	Mean	4.14	3.00
	Median	4.00	4.00
	Std. Deviation	0.90	1.41
p Value		0.500	0.028
Significance		Not Significant	Significant



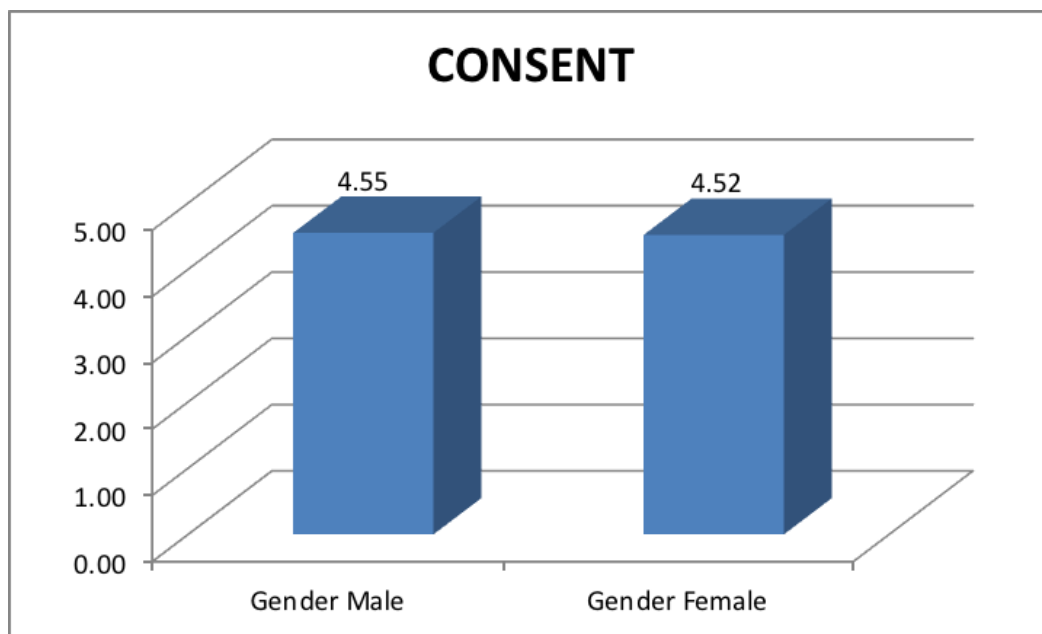


2. Are you?

Gender	Frequency	Percent
Male	196	56.0
Female	154	44.0
Total	350	100.0

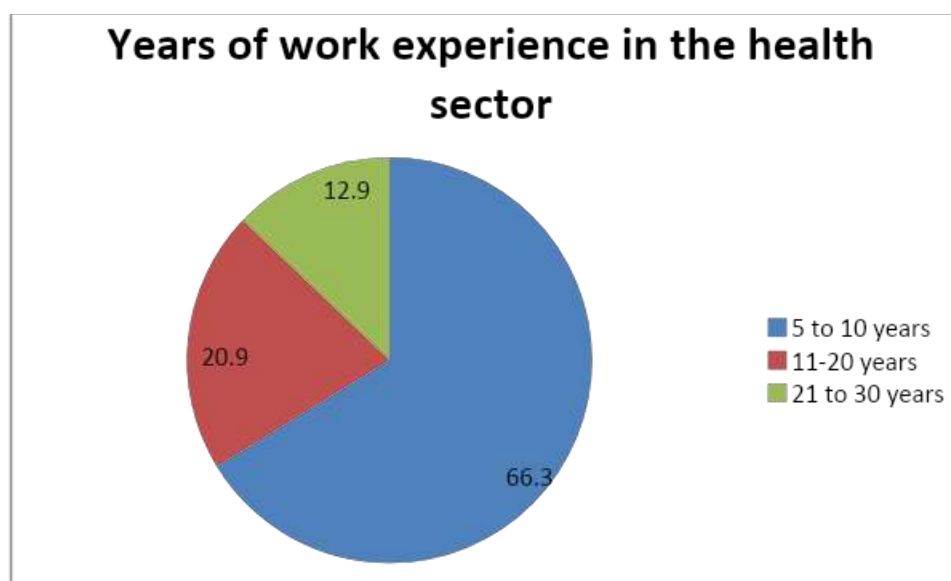


Gender		CONSENT	CAPACITY
Male	Mean	4.55	2.59
	Median	5.00	3.00
	Std. Deviation	0.84	1.03
Female	Mean	4.52	2.47
	Median	5.00	3.00
	Std. Deviation	0.96	1.16
	p Value	0.822	0.395
	Significance	Not Significant	Not Significant



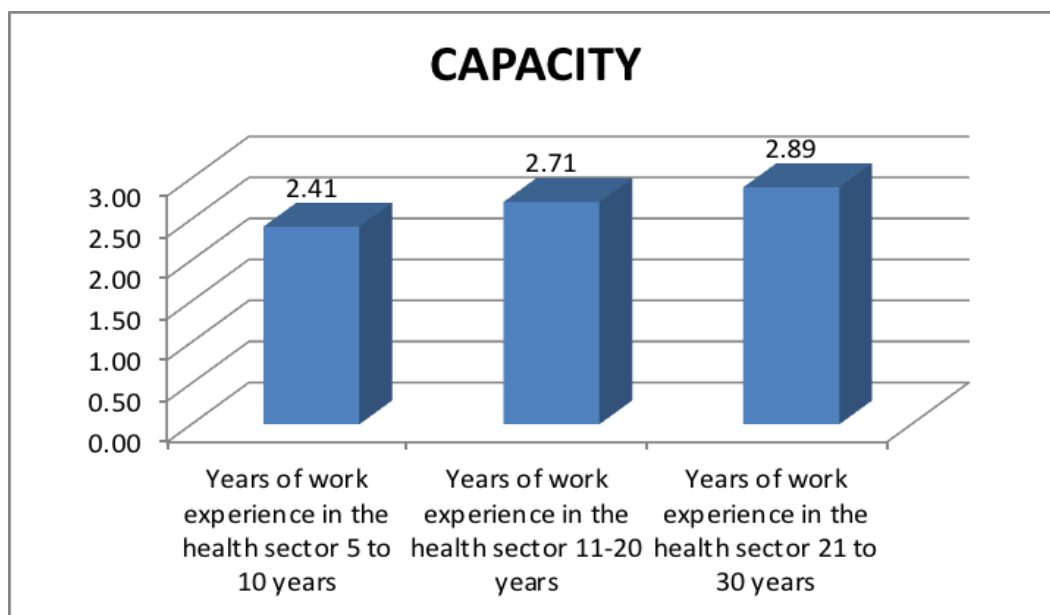
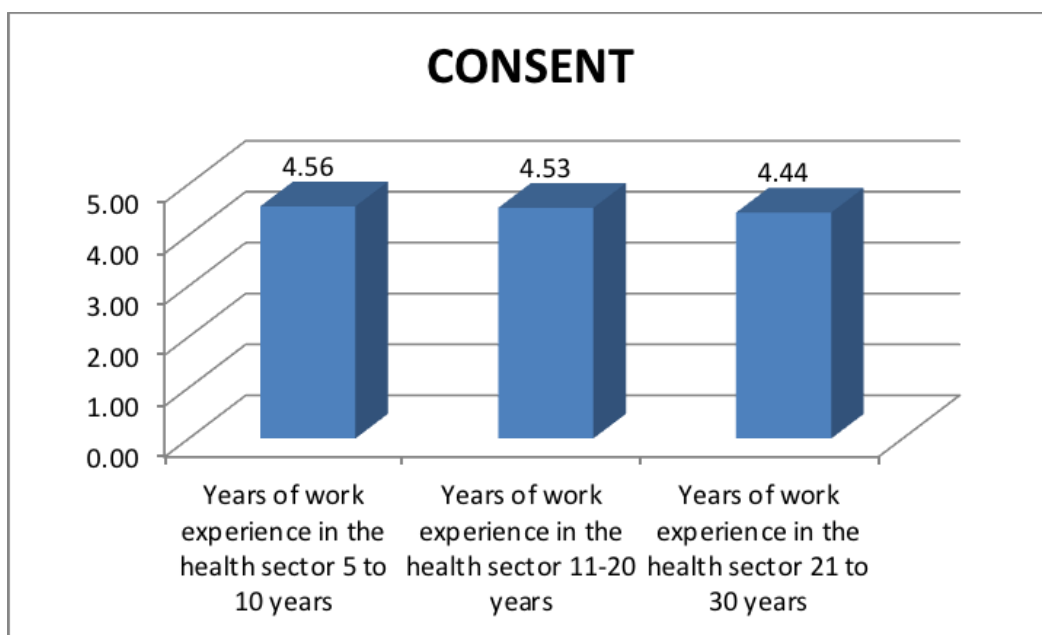
How many years of work experience in the health sector do you presently have?

How many years of work experience in the health sector do you presently have?	Frequency	Percent
5 to 10 years	232	66.3
11-20 years	73	20.9
21 to 30 years	45	12.9
Total	350	100.0



How many years of work experience in the health sector do you presently have?		CONSENT	CAPACITY
5 to 10 years	Mean	4.56	2.41
	Median	5.00	2.00
	Std. Deviation	0.92	1.12
11-20 years	Mean	4.53	2.71

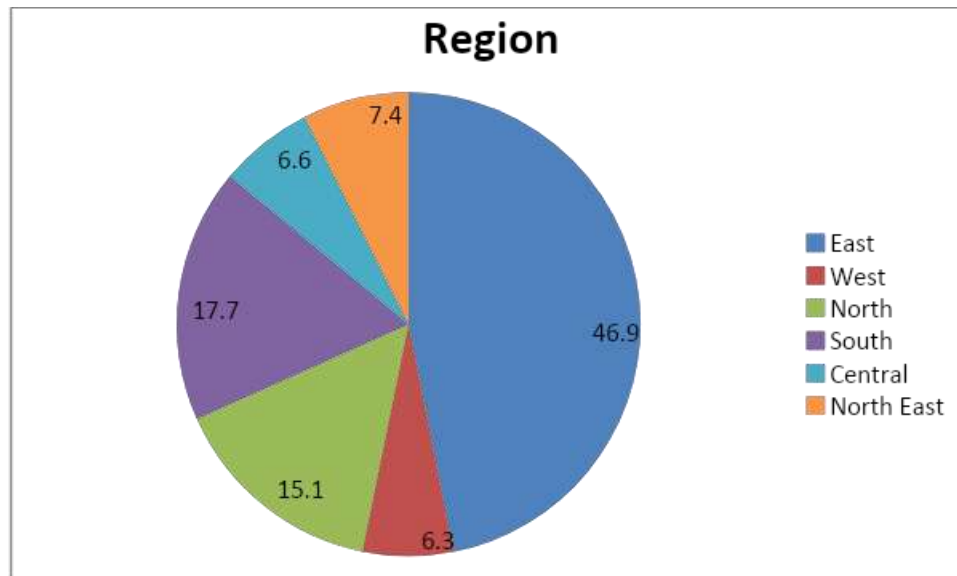
21 to 30 years	Median	5.00	3.00
	Std. Deviation	0.85	1.02
	Mean	4.44	2.89
	Median	5.00	3.00
	Std. Deviation	0.84	0.96
	p Value	0.554	0.010
	Significance	Not Significant	Significant



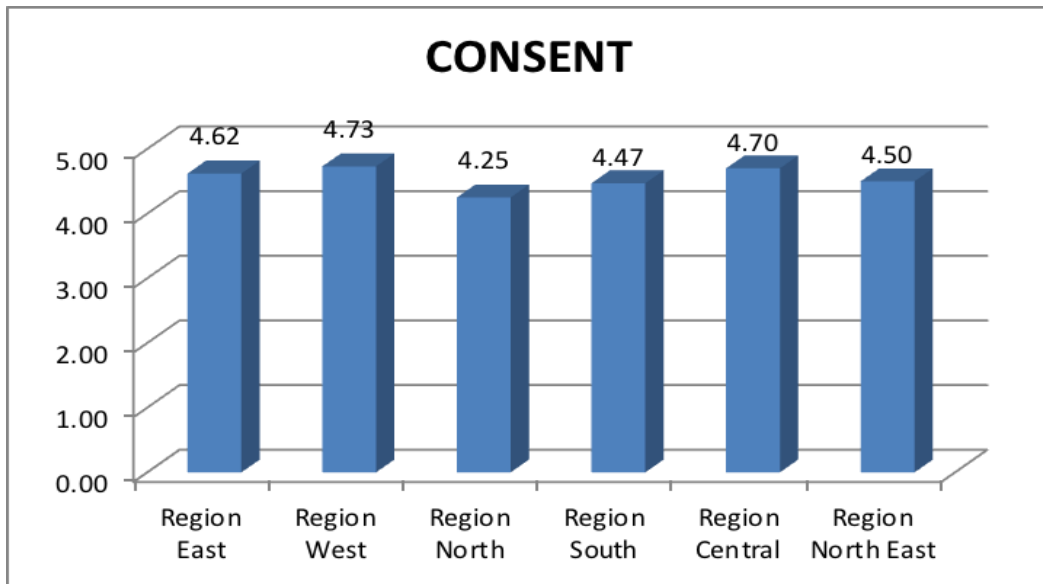
Which State/Union Territory you presently work in?

Region	Frequency	Percent
East	164	46.9
West	22	6.3
North	53	15.1

South	62	17.7
Central	23	6.6
North East	26	7.4
Total	350	100.0

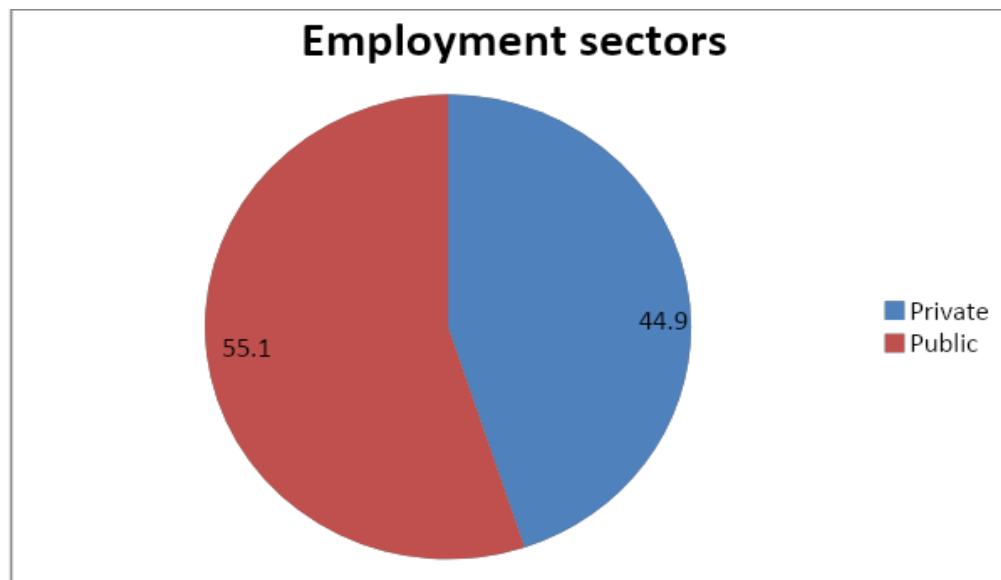


Region		CONSENT	CAPACITY
East	Mean	4.62	2.57
	Median	5.00	2.50
	Std. Deviation	0.79	1.07
West	Mean	4.73	2.73
	Median	5.00	3.00
	Std. Deviation	0.83	1.03
North	Mean	4.25	2.42
	Median	4.00	2.00
	Std. Deviation	1.04	1.10
South	Mean	4.47	2.56
	Median	5.00	3.00
	Std. Deviation	1.05	1.18
Central	Mean	4.70	2.61
	Median	5.00	3.00
	Std. Deviation	0.88	1.03
North East	Mean	4.50	2.27
	Median	5.00	2.00
	Std. Deviation	0.81	1.08
p Value		0.199	0.669
Significance		Not Significant	Not Significant

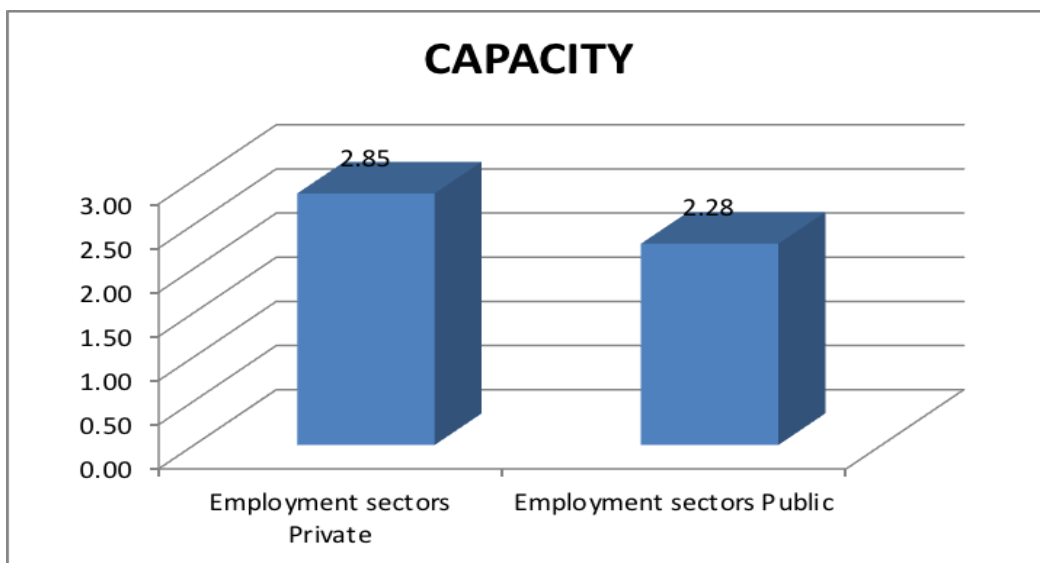
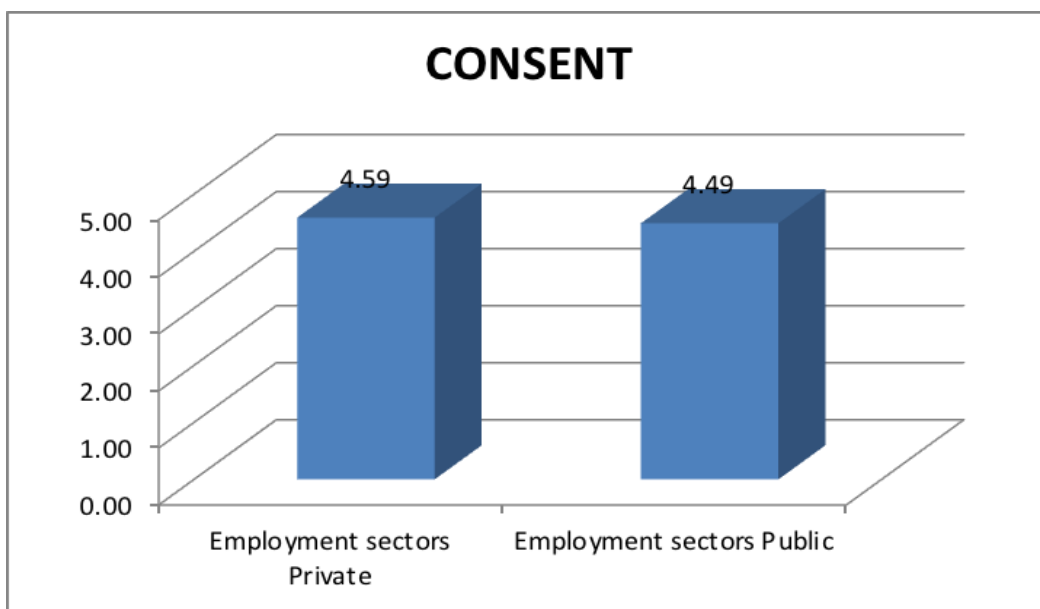


Which category of employment sectors represents best your employment for your main job?

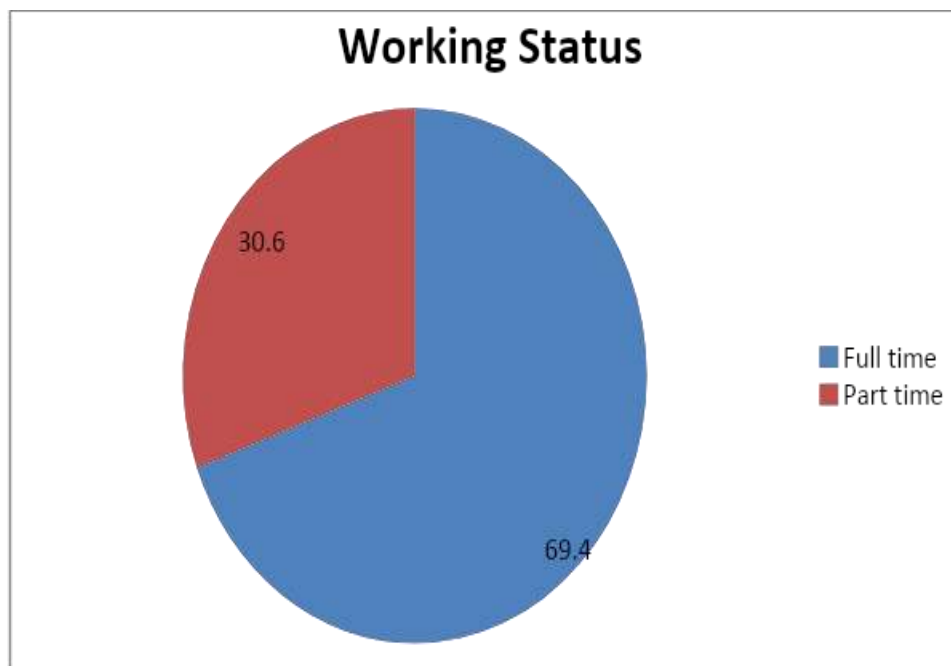
Employment sectors	Frequency	Percent
Private	157	44.9
Public	193	55.1
Total	350	100.0



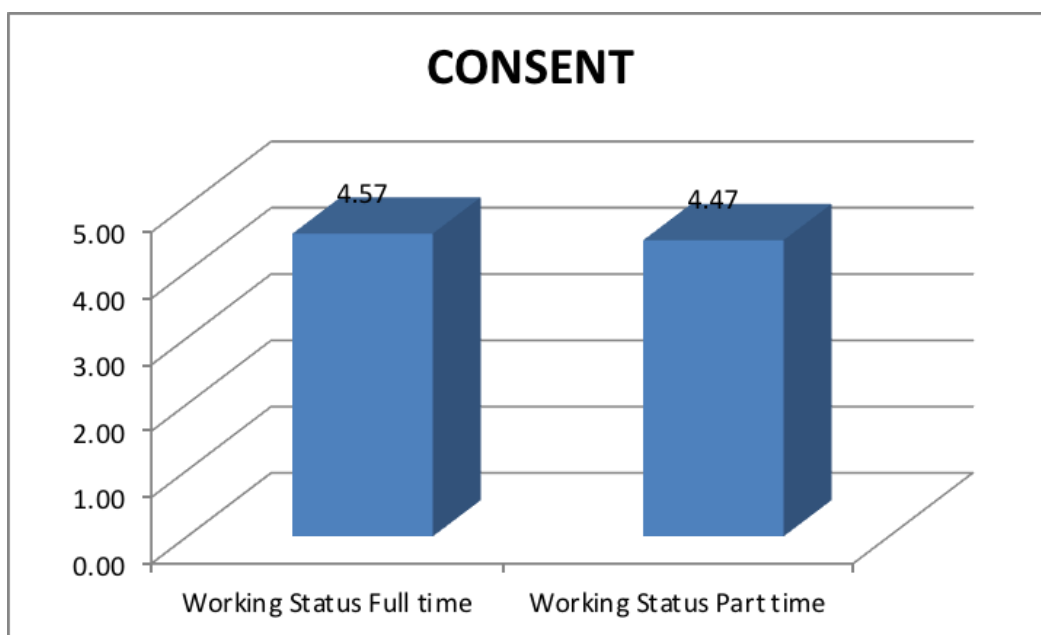
Employment sectors		CONSENT	CAPACITY
Private	Mean	4.59	2.85
	Median	5.00	3.00
	Std. Deviation	0.88	1.01
Public	Mean	4.49	2.28
	Median	5.00	2.00
	Std. Deviation	0.90	1.09
p Value		0.152	<0.001
Significance		Not Significant	Significant

**Do you work?**

Do you work?	Frequency	Percent
Full time	243	69.4
Part time	107	30.6
Total	350	100.0

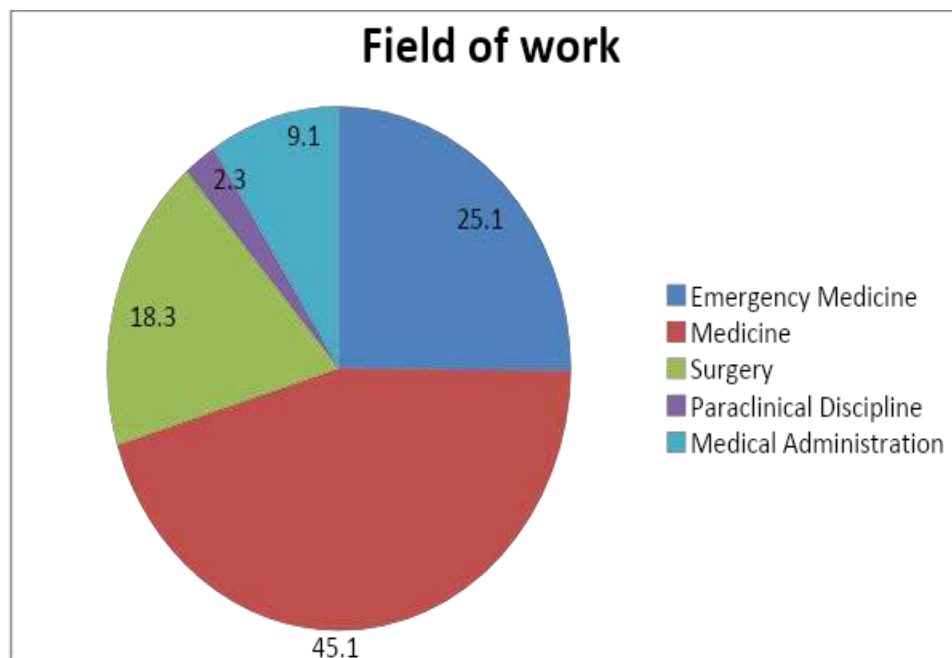


Do you work?		CONSENT	CAPACITY
Full time	Mean	4.57	2.59
	Median	5.00	3.00
	Std. Deviation	0.87	1.15
Part time	Mean	4.47	2.42
	Median	5.00	2.00
	Std. Deviation	0.94	0.93
p Value		0.463	0.101
Significance		Not Significant	Not Significant

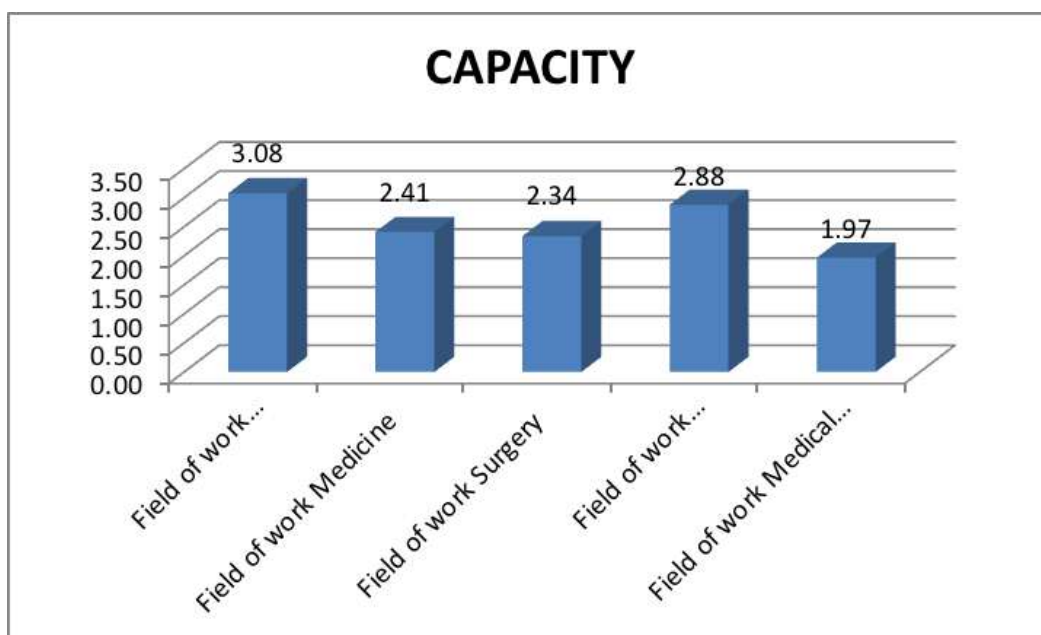
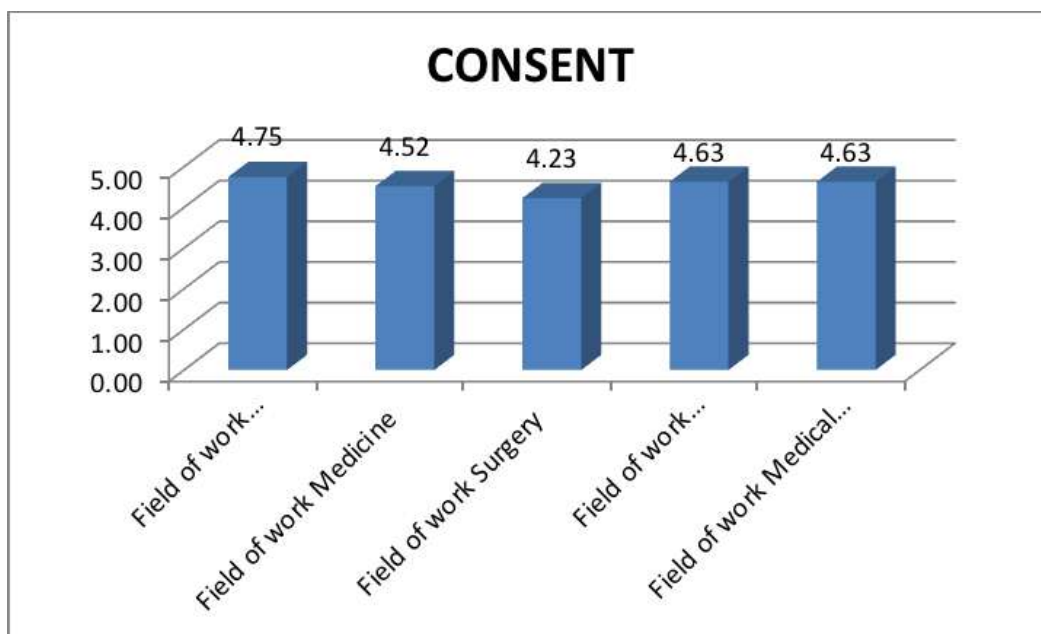


What is your field of work?

What is your field of work	Frequency	Percent
Emergency Medicine	88	25.1
Medicine	158	45.1
Surgery	64	18.3
Paraclinical Discipline	8	2.3
Medical Administration	32	9.1
Total	350	100.0



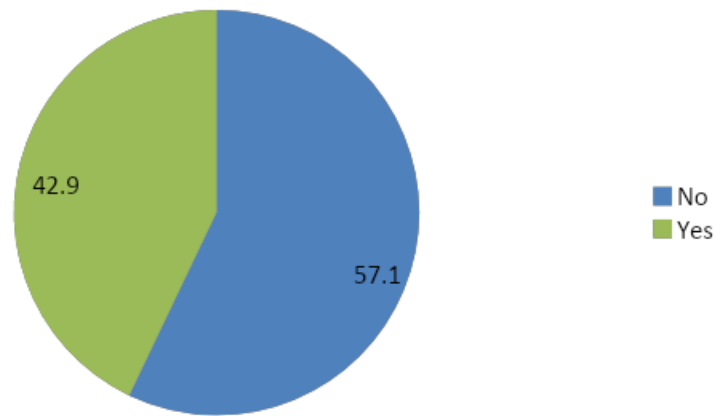
What is your field of work		CONSENT	CAPACITY
Emergency Medicine	Mean	4.75	3.08
	Median	5.00	3.00
	Std. Deviation	0.75	0.99
Medicine	Mean	4.52	2.41
	Median	5.00	2.00
	Std. Deviation	0.93	1.05
Surgery	Mean	4.23	2.34
	Median	4.00	2.00
	Std. Deviation	0.99	1.03
Paraclinical Discipline	Mean	4.63	2.88
	Median	5.00	3.50
	Std. Deviation	0.74	1.36
Medical Administration	Mean	4.63	1.97
	Median	5.00	2.00
	Std. Deviation	0.79	1.06
p Value		0.009	<0.001
Significance		Significant	Significant



Can a 16 year old person give consent for operation of organ transplant?

Can a 16 year old person give consent for operation of organ transplant?	Frequency	Percent
No	200	57.1
Yes	150	42.9
Total	350	100.0

Can a 16 year old person give consent for operation of organ transplant?



According to Section 11 of The Indian Contract Act, only people ‘of and above’ 18 years of age can give valid consent. However “Double Consent” must be obtained from both the child and his/her parents if the child is between 12 to 18 years of age and is of reasonably sound mind (Gillick-competent).[31]. As per the Code of Practice issued by the Human Tissue Authority, in Gillick-competent cases, a Court order is mandatory.[32].

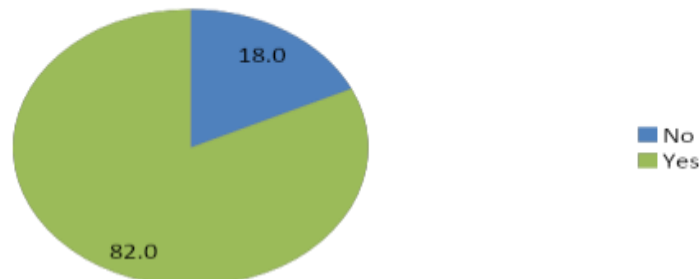
Statistical analysis of data pertaining to the Emergency Department across private and public institutions is as follows:-

		Can a 16 year old person give consent for operation of organ transplant?		Total		
		No	Yes		p Value	Significance
Employment sectors	Private	22[78.57]	55[91.67]	77[87.5]	0.097	Not Significant
	Public	6[21.43]	5[8.33]	11[12.5]		
Total		28[100]	60[100]	88[100]		

Is the consent taken from the local guardian of a mentally unsound person valid?

Is the consent taken from the local guardian of a mentally unsound person valid?	Frequency	Percent
No	63	18.0
Yes	287	82.0
Total	350	100.0

Is the consent taken from the local guardian of a mentally unsound person valid?



In India, there are no clear protocols for obtaining consent for treatment of a mentally unsound person.[31]. Proxy/ Substitute consent can be given either by a legal guardian, any patient attender or the treating the doctor himself/herself, as the situation demands.

Statistical analysis of data pertaining to the Emergency Department across private and public institutions is as follows:-

		Is the consent taken from the local guardian of a mentally unsound person valid?		Total		
		No	Yes			
Employment sectors	Private	9[90]	68[87.18]	77[87.5]	0.800	Not Significant
	Public	1[10]	10[12.82]	11[12.5]		
Total		10[100]	78[100]	88[100]		

Should a written consent be obtained for medico legal examination for determining age, potency, virginity etc where the person examined is not in police custody?

Should a written consent be obtained for medico legal examination for determining age, potency, virginity etc where the person examined is not in police custody?	Frequency	Percent
No	4	1.1
Yes	346	98.9
Total	350	100.0

Should a written consent be obtained for medico legal examination for determining age, potency, virginity etc where the person examined is not in police custody?



Article 21 of the Indian Constitution ensures patient's legal right to autonomy. Hence a medical practitioner cannot treat or even examine a patient without his/her consent. At least an implied consent is required to do so.[33]. However, Section 53[1] of the Code of Criminal Procedure, states that if requested by the police, a person may be examined by a doctor, by use of force.

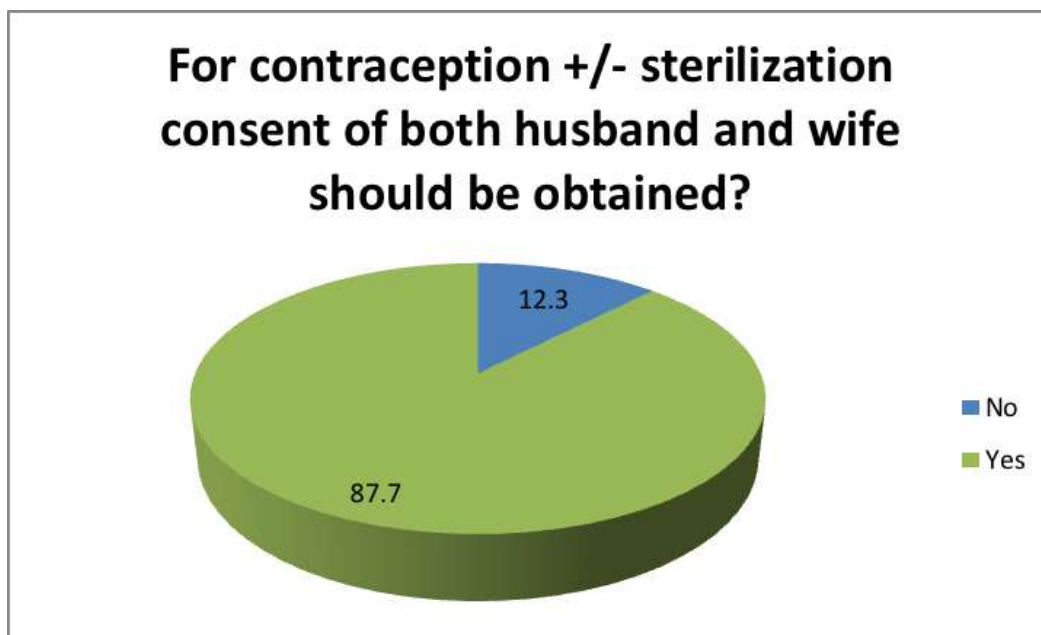
Statistical analysis of data pertaining to the Emergency Department across private and public institutions is as follows:-

		Should a written consent be obtained for medico legal examination for determining age, potency, virginity etc where the person examined is not in police custody?		Total		
		No	Yes			
Employment	Private	1[100]	76[87.36]	77[87.5]	0.875	Not

sectors	Public	0[0]	11[12.64]	11[12.5]		Significant
Total		1[100]	87[100]	88[100]		

For contraception +/- sterilization consent of both husband and wife should be obtained?

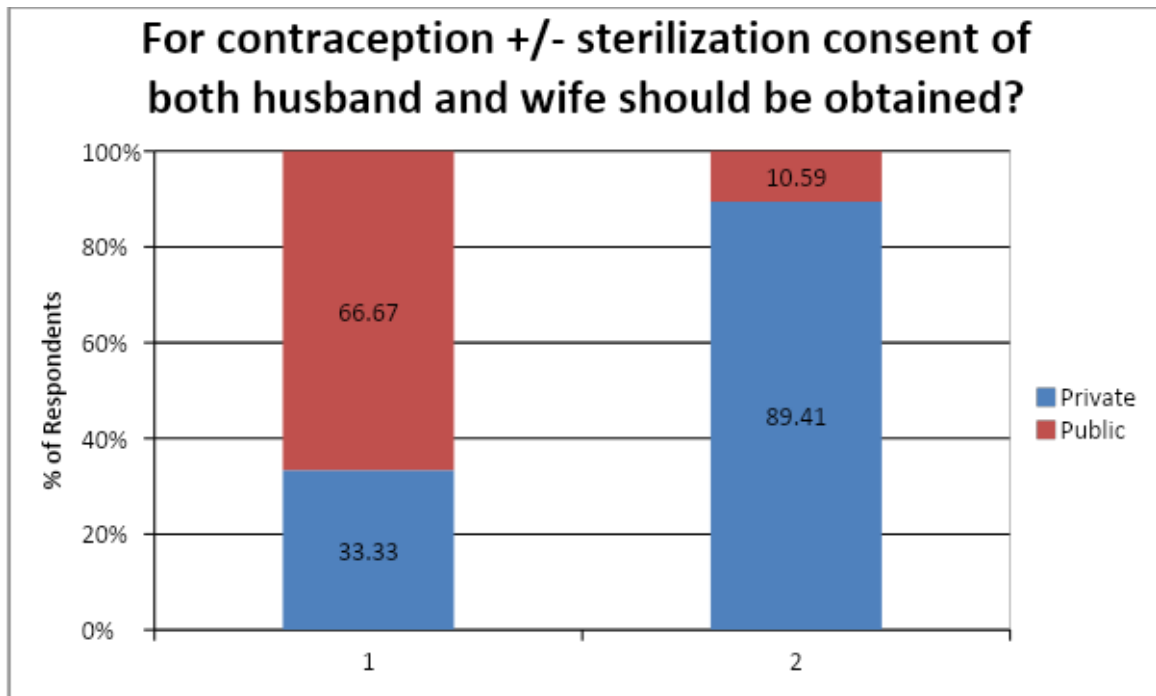
For contraception +/- sterilization consent of both husband and wife should be obtained?	Frequency	Percent
No	43	12.3
Yes	307	87.7
Total	350	100.0



Consent of both the husband and wife is necessary in case of contraception +/- sterilization.[31].

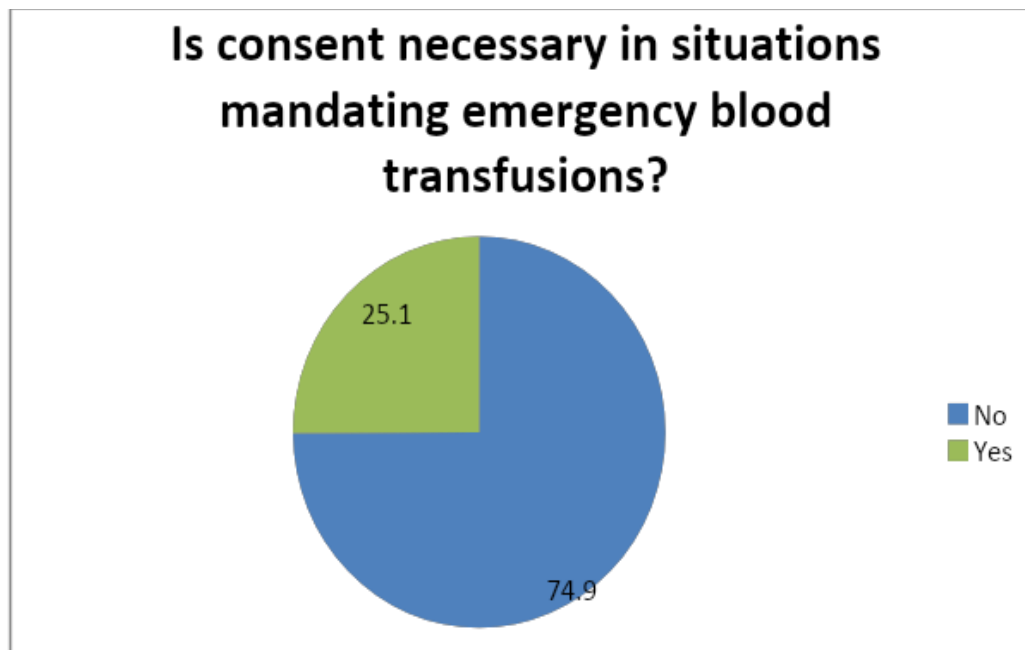
Statistical analysis of data pertaining to the Emergency Department across private and public institutions is as follows:-

		For contraception +/- sterilization consent of both husband and wife should be obtained?		Total	p Value	Significance
		No	Yes			
Employment sectors	Private	1[33.33]	76[89.41]	77[87.5]	0.040	Significant
	Public	2[66.67]	9[10.59]	11[12.5]		
Total		3[100]	85[100]	88[100]		



Is consent necessary in situations mandating emergency blood transfusions?

Is consent necessary in situations mandating emergency blood transfusions?	Frequency	Percent
No	262	74.9
Yes	88	25.1
Total	350	100.0



Consent is not necessary in situations mandating emergency blood transfusions, where the transfusion is deemed to be a life saving procedure.[34]. The fact that the patient has been brought to the hospital serves as an implied consent in

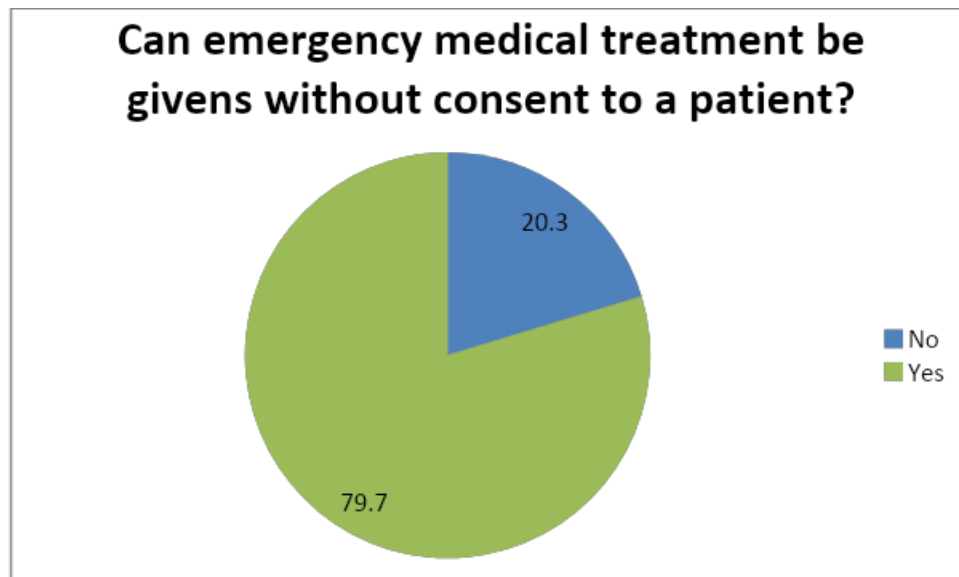
itself from the part of the patient companion. As Lord Bridge had observed, had this provision not been made, doctors would have faced an unfathomable dilemma.[35].

Statistical analysis of data pertaining to the Emergency Department across private and public institutions is as follows:-

		Is consent necessary in situations mandating emergency blood transfusions?		Total	p Value	Significance
		No	Yes			
Employment sectors	Private	61[87.14]	16[88.89]	77[87.5]	0.842	Not Significant
	Public	9[12.86]	2[11.11]	11[12.5]		
Total		70[100]	18[100]	88[100]		

Can emergency medical treatment be given to a patient without consent?

Can emergency medical treatment be given without consent to a patient?	Frequency	Percent
No	71	20.3
Yes	279	79.7
Total	350	100.0



Doctors may lawfully proceed to treat a patient requiring emergent medical assistance only in situations where an otherwise competent patient is unable to consent for certain reasons. Law states that this is a “fictional” implied consent i.e. had this patient been conscious, he/she would have consented to emergency medical treatment.[31].

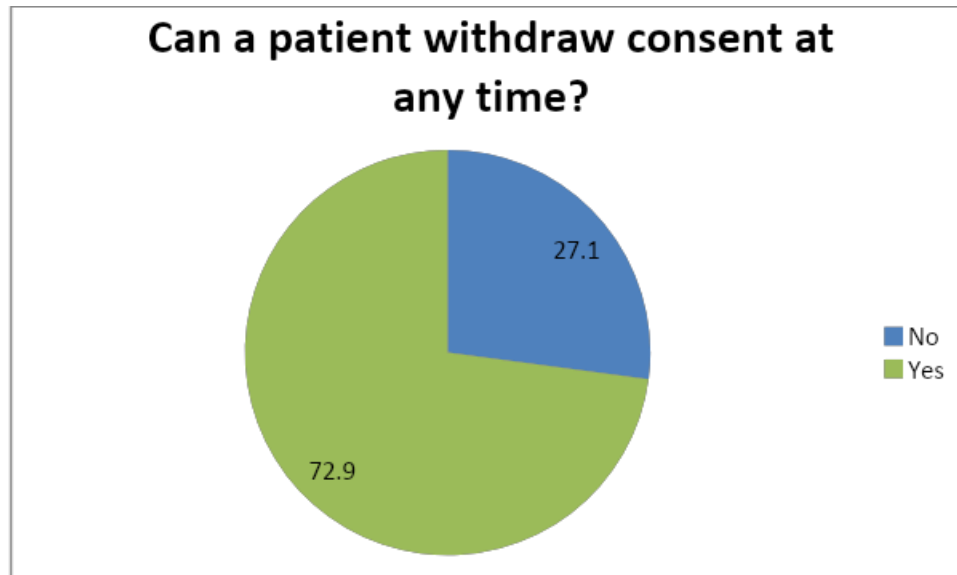
Statistical analysis of data pertaining to the Emergency Department across private and public institutions is as follows:-

		Can emergency medical treatment be given without consent to a patient?		Total	p Value	Significance
		No	Yes			
Employment sectors	Private	12[85.71]	65[87.84]	77[87.5]	0.826	Not Significant
	Public	2[14.29]	9[12.16]	11[12.5]		
Total		14[100]	74[100]	88[100]		

Can a patient withdraw consent at any time?

Can a patient withdraw consent at any time?	Frequency	Percent
No	95	27.1

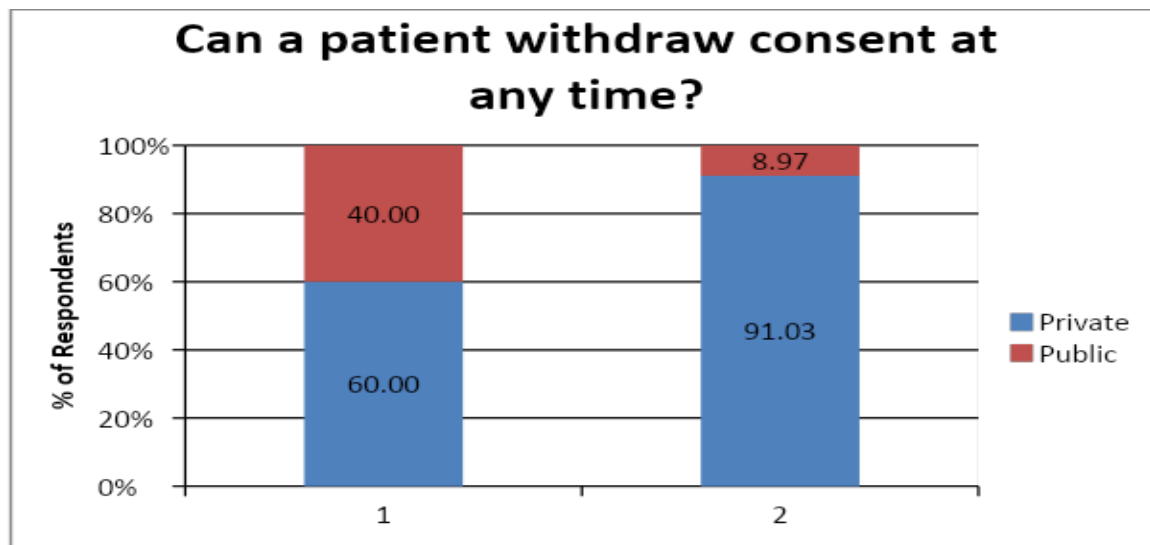
Yes	255	72.9
Total	350	100.0



There are no established Indian laws for this. The UK Department of Health Guidance states that “A person with capacity is entitled to withdraw consent at any time, including during the performance of a procedure”. However, the fact that no Courts of Law across the world has not yet legally adopted active euthanasia, speaks against it. If a patient withdraws his/her consent during an on-going procedure, the procedure must be stopped by the doctor immediately unless it [the stoppage] poses as a life-risking event.[36].

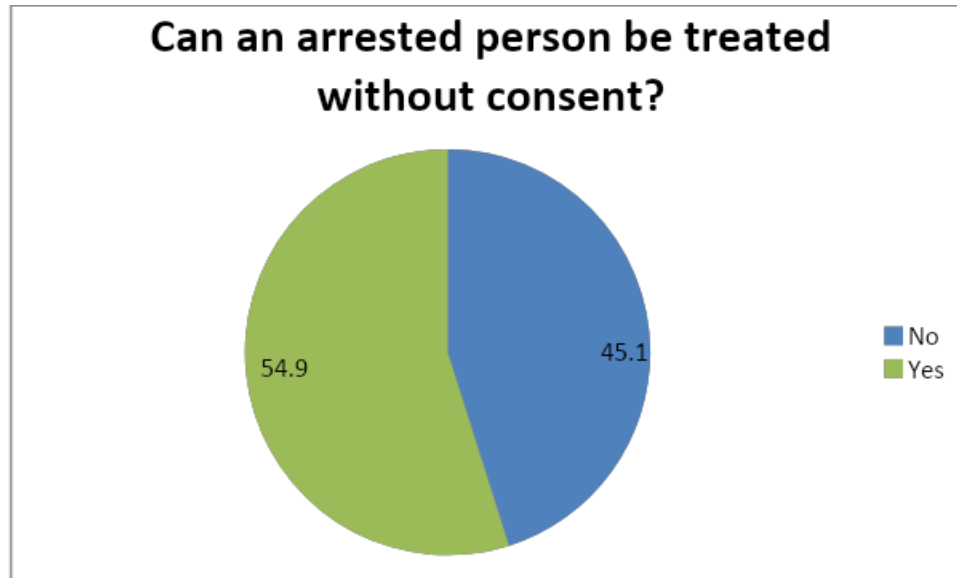
Statistical analysis of data pertaining to the Emergency Department across private and public institutions is as follows:-

		Can a patient withdraw consent at any time?		Total	p Value	Significance
		No	Yes			
Employment sectors	Private	6[60]	71[91.03]	77[87.5]	0.020	Significant
	Public	4[40]	7[8.97]	11[12.5]		
Total		10[100]	78[100]	88[100]		



Can an arrested person be treated without consent?

Can an arrested person be treated without consent?	Frequency	Percent
No	158	45.1
Yes	192	54.9
Total	350	100.0



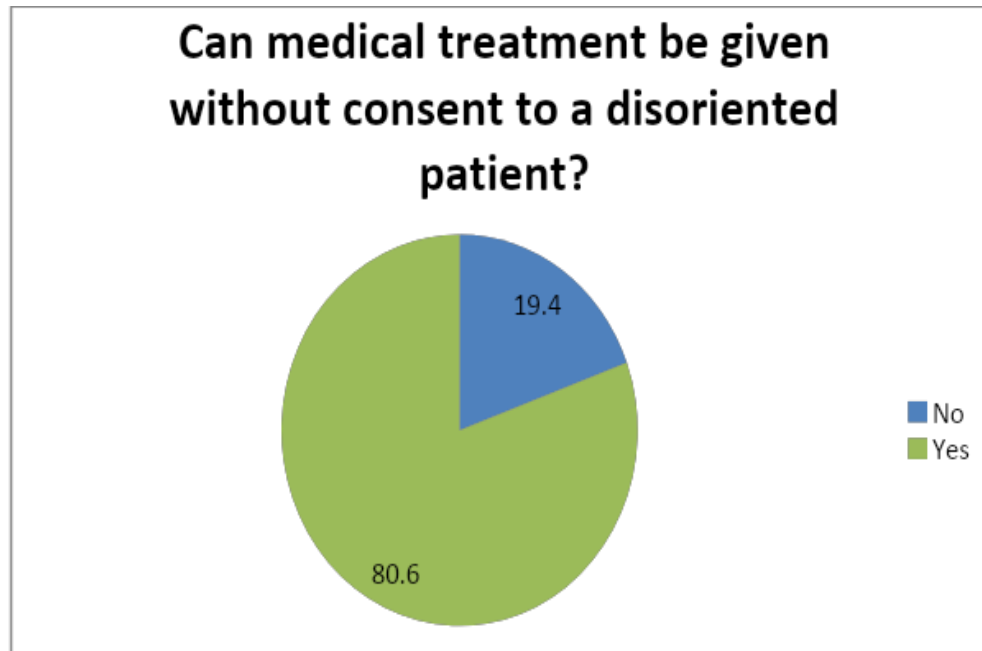
Section 53[1] of the Code of Criminal Procedure, states that if requested by the police, a person may be examined by a doctor, by use of force. Section 53[2] states that in such circumstances, a female person who has been arrested, must always be examined by or under the supervision of a female doctor.

Statistical analysis of data pertaining to the Emergency Department across private and public institutions is as follows:-

		Can an arrested person be treated without consent?		Total	p Value	Significance
		No	Yes			
Employment sectors	Private	25[89.29]	52[86.67]	77[87.5]	0.729	Not Significant
	Public	3[10.71]	8[13.33]	11[12.5]		
Total		28[100]	60[100]	88[100]		

Can medical treatment be given without consent to a disoriented patient?

Can medical treatment be given without consent to a disoriented patient?	Frequency	Percent
No	68	19.4
Yes	282	80.6
Total	350	100.0



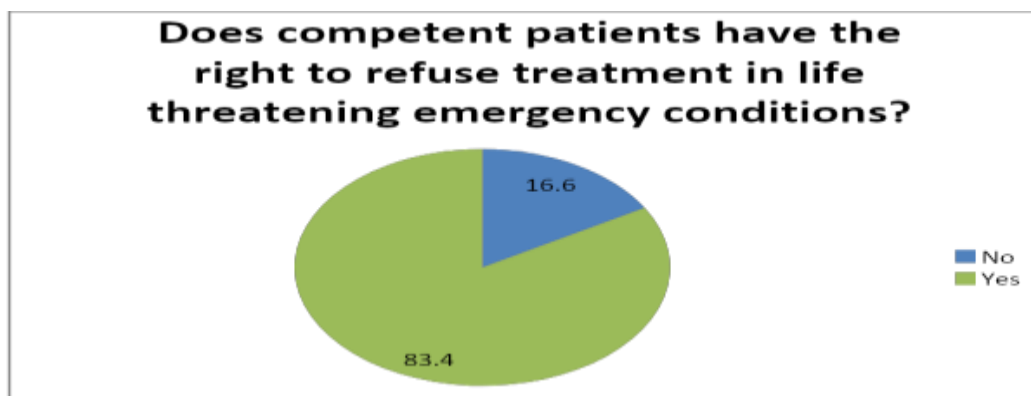
Medical treatment can be given without consent to a disoriented patient, if the doctor feels that there is a necessity for so. However the liability of proving the necessity of the treatment lies with the doctor.[31] [36].

Statistical analysis of data pertaining to the Emergency Department across private and public institutions is as follows:-

		Can medical treatment be given without consent to a disoriented patient?		Total	p Value	Significance
		No	Yes			
Employment sectors	Private	9[81.82]	68[88.31]	77[87.5]	0.542	Not Significant
	Public	2[18.18]	9[11.69]	11[12.5]		
Total		11[100]	77[100]	88[100]		

Does competent patients have the right to refuse treatment in life threatening emergency conditions?

Do competent patients have the right to refuse treatment in life threatening emergency conditions?	Frequency	Percent
No	58	16.6
Yes	292	83.4
Total	350	100.0



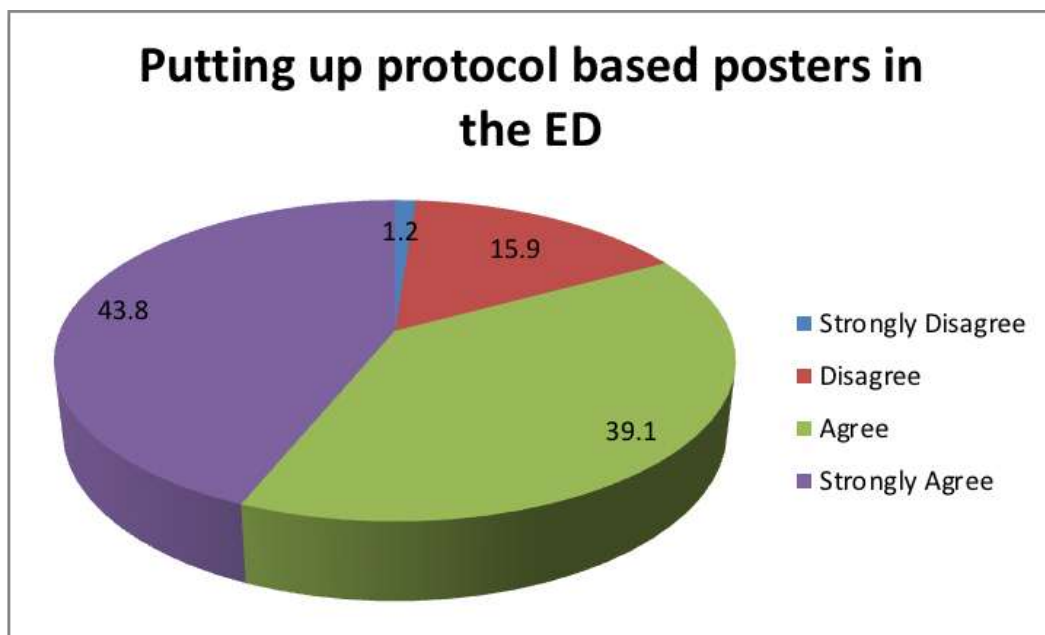
Competent patients does have the right to refuse treatment in life threatening emergency conditions.[37]. However, this refusal must be documented and be signed by the patient himself/herself.

Statistical analysis of data pertaining to the Emergency Department across private and public institutions is as follows:-

		Do competent patients have the right to refuse treatment in life threatening emergency conditions?		Total		
		No	Yes			
Employment sectors	Private	12[85.71]	65[87.84]	77[87.5]	0.826	Not Significant
	Public	2[14.29]	9[12.16]	11[12.5]		
Total		14[100]	74[100]	88[100]		

Putting up protocol based posters in the ED.

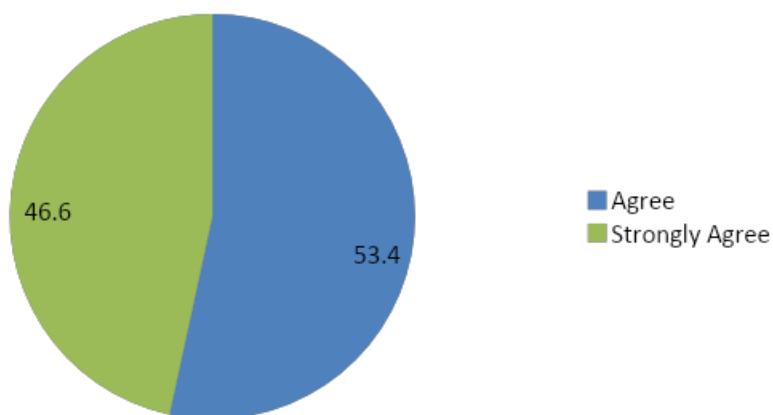
Putting up protocol based posters in the ED	Frequency	Percent
Strongly Disagree	4	1.2
Disagree	54	15.9
Agree	133	39.1
Strongly agree	149	43.8
Total	340	100.0



Do you think regular updates on consent taking protocols will help?

Do you think regular updates on consent taking protocols will help?	Frequency	Percent
Agree	187	53.4
Strongly Agree	163	46.6
Total	350	100.0

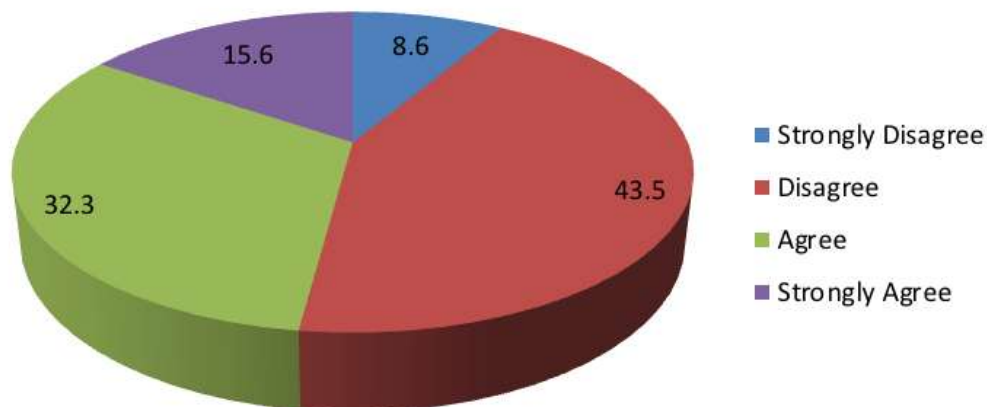
Do you think regular updates on consent taking protocols will help?



Do you think we need medical law incorporated in MBBS course?

Do you think we need medical law incorporated in MBBS course?	Frequency	Percent
Strongly Disagree	30	8.6
Disagree	151	43.5
Agree	112	32.3
Strongly agree	54	15.6
Total	347	100.0

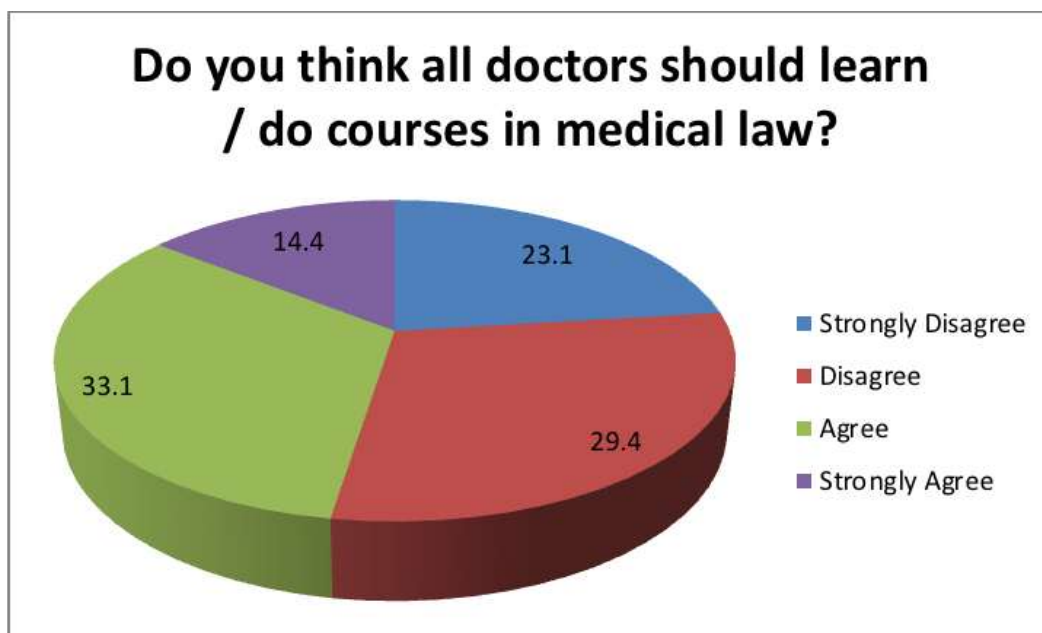
Do you think we need medical law incorporated in MBBS course?



Do you think all doctors should learn/ do courses in medical law?

Do you think all doctors should learn / do courses in medical law?	Frequency	Percent
Strongly Disagree	80	23.1
Disagree	102	29.4

Agree	115	33.1
Strongly agree	50	14.4
Total	347	100.0



Discussion:-

Having completed the study, it is found that there is no significant difference in knowledge regarding consent-taking practices amongst doctors working in private vs public health institutions [p value > 0.05]. However, there is a significant difference in knowledge regarding capacity to consent [p value < 0.05]. Doctors working in the Emergency Department possess greater knowledge regarding consent-taking practices and who has the capacity to give a valid consent, when compared to other disciplines. Responses obtained from doctors working in the Emergency Department across the country (88/350) have been separately analysed using Pearson's Chi Square Test for Independence Attributes/Fisher's Exact Test as applicable. It has been found that there is a significant difference in knowledge amongst doctors working in private vs public sectors regarding consent taking practices for sterilisation/contraceptive procedures. 89.41% of doctors working in private sectors believe that the consent for sterilisation/contraceptive procedures must be obtained from both the husband and the wife whereas 66.67% of doctors working in public sector does not believe so. There is also a significant difference noted in knowledge of doctors regarding who has the capacity to withdraw consent. 91.03% of doctors working in public sector believes that the patient can withdraw consent to treatment at any time during its course whereas only 8.97% of doctors working in the public sector believes so. However, on an average, the doctors working across the Emergency Department in the country, regardless of private or government setup, have not been able to give a promising response regarding their quality of knowledge on consent and capacity.

It has also been observed that advancing age and greater years of practice is associated with better knowledge of who has the capacity to consent (mean value of 3.00 and 2.89 respectively). However, none of these are significantly different between private and public institutions. Doctors working full time in a particular setup (private or public) has better knowledge regarding consent-taking practices and who has the capacity to consent (mean value of 4.57 and 2.59 respectively).

Interestingly it has been observed that knowledge regarding consent-taking practices is the highest amongst the newer age doctors (mean value of 4.56).

In fact a good 43.8% of doctors, across all disciplines, believe that protocol based posters should be put up in the Emergency Department. A greater percentage of doctors is also found to have agreed to regular updates on consent

taking protocols or incorporating the medical law in MBBS course. But then again it has been found only 33.1% of doctors across the country agree to the idea of courses in medical law.

In a nutshell, it may be concluded that doctors in India are still profoundly confused regarding consent-taking practices. It is high time that this lacuna is addressed or else the medical profession is sure to turn into a whirlpool of medicolegal nightmare for the medical practitioner. Although the Emergency is still an emerging discipline in the Indian medical scenario, doctors practising in this arena do need to be specially trained regarding medicolegal aspects as there are important, life-saving decisions taken in this department within very short span of time. Those pre-existing disciplines that are still connected to consent-taking practices from the patient also need to restructure their standard operating procedures in the medicolegal arena. It is not known till now whether bills or amendments or introduction of new courses will bring about this awareness, but the awakening has to be accomplished- the sooner, the better. This study may serve as a torchbearer to this mission.

Study limitations:

1. The study population has been tested upon a confined set of questionnaire and it might not have covered the entire range of pertinent questions.
2. There is unequal representation from private and public sector which may have influenced the statistical analysis.
3. Physicians have been selected randomly around the country, which might not have reflected the ideal demographic scenario of physicians in our country.
4. As the questionnaires have been distributed by e-mails, there is a high possibility of identity theft.

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