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BARRIERS FOR OBTAINING INFORMED CONSENT AMONG CHILDREN AND THE MENTALLY ILL IN INDIA

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ABSTRACT

Informed consent lies at the intersection of medical ethics and law, yet it becomes difficult to apply for patients whose capacity to decide is doubtful. This paper examines the barriers to obtaining valid consent from two such groups in India — the mentally ill and children. It traces the evolution of consent from medical paternalism to mandatory disclosure, drawing on the Nuremberg Code, the Declaration of Helsinki and leading common law decisions. It then analyses the Indian position, including the Mental Healthcare Act, 2017, which presumes capacity in persons with mental illness, and the Medical Council of India Regulations and Samira Kohli, which place consent for minors in the hands of parents or guardians. The paper finds that India law has not adopted the “mature minor” standard from Gillick, leaving little room for a minor’s own opinion. It recommends tailoring the consent process to a patient’s specific deficits and giving effect to the choices of mature minors, so that autonomy is protected in practice.

INTRODUCTION

Consent is a process that allows for the free expression of an informed choice, by a person capable of participating in a study or a treatment. What the concept of consent purports to do is uphold an individual's autonomy, and their right to choose by rational decision-making that is based on a complete appraisal of their options, alternatives, as well as their willingness to engage. It is one of the most crucial components of healthcare and biomedical research today. Informed consent involves ethical, medical as well as legal dimensions pertaining to medical intervention. It is an obligation on a service provider – medical practitioners, in this scenario –

to communicate with the service-seeker – or the patient – for the proposed treatment, based on simple explanations of the need for such medical intervention, alternate options, realistic explanations of each intervention rooted in the potential risks and benefits — thus, helping the patient arrive at an appropriate course of action, that wasn't reached out of undue influence or coercion.

The intertwining nature of law and ethics is evident in a myriad aspects of life, and this is particularly noticeable in the field of healthcare. When law comes together on the subject, it does so as a social consensus on ethics. A primary issue at the centre of the doctor-patient relationship in the intersection of law and medicine is '**informed consent**'. This concept – which found its origins in clinical ethics – has been at the forefront of biomedical ethics since the Nuremberg trials, as well as other instances of human experimentation. The idea of informed consent moved from shared decision-making between the doctor and the patient to requiring an individual's autonomous authorisation to undergo medical interventions.

In the last half-century or so, medicinal practices have slowly, but surely, moved from a paternalistic view where the doctor unilaterally decides what is in the best interests of the patient, to a collaborative approach where information is duly disclosed to the patients – or caregivers, in certain circumstances – for decision-making. Informed consent is, at its core, about giving a patient the specific knowledge that equips them to take decisions in an informed manner. This is done to promote individual autonomy and freedom of choice. Such consent has four essential elements — *first*, capacity of the patient in question to give such consent; *second*, voluntariness or willingness of such an individual in undertaking the treatment, that is not borne out of coercion; *third*, decision-making, that is, the ability to take decisions; and *lastly*, knowledge, in that sufficient information has been shared with the patient so as to understand the nature and consequences of the treatment. For a consent to be considered legally valid, all these elements must be present.¹

In psychiatry, however, consent is interpreted differently — the aforementioned decision-making component can be affected in a psychiatric illness, owing to deficits in mental abilities that may mean impairments in attention, mood, understanding and reasoning.² The capacity for rational decision-making comprises different cognitive abilities such as being able to logically reason between the choices, understanding the information disclosed, being able to effectively

¹ Dalal PK, *Consent in Psychiatry – Concept, Application & Implications*, 1 INDIAN J MED RES. 6, 7-8 (2020).

² *Ibid.*

communicate, as well as appreciating the significance of the decision. There is a concept of capacity to consent for psychiatric patients, which is assessed by competence — the capacity to understand the options placed before one, and use such information in a rational manner to reach an appropriate conclusion is what is referred to as ‘competency’.³

There are several developments or aspects that makes the study of informed consent all the more complicated — similar to the challenge posed by those who are thought of as mentally ill, are minors. Both categories of patients who are, at time, no capable of consenting to medical treatment by themselves — this would only pose a dilemma for a doctor tasked with their treatment. For example, if a minor is seeking to undergo a treatment either without their parents’/guardian, or if the guardian refuses to consent while the minor does (or vice versa) — these are some of the questions that this research paper wishes to address.

EVOLUTION OF INFORMED CONSENT — FROM PATERNALISM TO MANDATORY DISCLOSURE

In the Hippocratic era, paternalism largely coloured medical practice — as per the man, the physician must, *“speak to the patient carefully and adroitly, concealing most things”*.⁴ Providing utmost benefit to the patient while avoiding any harm from coming their way were the chief concerns, and full disclosure of illness/treatment was considered a violation of the same. The idea of consent, however, did not remain so for long — Plato, in Ancient Greece, connected consent with a man’s freedom;⁵ at the time of Alexander the Great and during the Byzantine era, consent of the patient was not merely considered necessary, but physicians demanded more safeguards before undertaking any difficult/critical operation owing to fear of something going fatally wrong⁶. Consent became an important part of the treatment process, not necessarily for recognising the rights of the patient, but sometimes to merely avoid any negative consequences.

³ T. Kitamura, *Assessment of Psychiatric Patients’ Competency to Give Informed Consent: Legal Safeguard of Civil Right to Autonomous Decision-making*, 5 PSYCHIATRY CLIN. NEUROSCI. 54, 57-58 (2000).

⁴ Furkhan Ali. et al, *Consent in Current Psychiatric Practice and Research: An Indian Perspective*, 4 INDIAN J PSYCHIATRY, 667, 667-668 (2019).

⁵ Furkhan Ali. et al, *Consent in Current Psychiatric Practice and Research: An Indian Perspective*, 4 INDIAN J PSYCHIATRY, 667, 668-669 (2019).

⁶ *Ibid.*

In the 1940s – while America was still stuck in the Jim Crow regime – a series of research abuses were carried out in Tuskegee, Alabama.⁷ The study was regarding the natural history of untreated syphilis, and it was conducted on African-American men from economically vulnerable backgrounds.⁸ The participants had not been informed of their disease, and were further denied medication as well despite the treatment becoming available in 1947. It was only in 1972 that these abuses and unethical practices came to light, following which the United States Congress passed the National Research Act and appointed a commission to study/frame regulations governing clinical trials.

It would be remiss to discuss the evolution of consent without bringing up the activities of Nazi Physicians — in 1947, these physicians were tried at Nuremberg, Germany, for the research atrocities, including drug trials, which they had performed on prisoners of war as well as captives at concentration camps without their consent.⁹ The Nuremberg Medical Trial (1946-1947) – also referred to as the Doctors’ Trial – is best known for its Nuremberg Code.¹⁰ As Chief Prosecutor General Telford Taylor had declared in his opening statement, this was no “*mere murder trial*”.¹¹ The United States Military Court and Tribunal – urged to declare the impugned acts the impugned acts, as well as “*the ideas which engendered them, as barbarous and criminal*”¹² – laid down ten points of the Nuremberg Code, that are required to be followed and adhered to in any clinical trial. It was the first internationally recognised code of ethics in the research field.¹³ The American judges, in an attempt to prevent such acts of savagery from ever occurring again, were able to come up with the Code — an important, historical document that requires medical researchers to treat trial participants as human beings, first and foremost, who have rights and dignity. In doing so, the judges proclaimed that Nuremberg, “*a place of evil*” was also “*a place of justice*”.¹⁴

While it had incredible influence on human rights globally, it was still felt that the Nuremberg Code was inadequate, barebones, and needed an update. Consequently, the World Medical

⁷ *Supra* note 5.

⁸ *Supra* note 5.

⁹ Evelyn Shuster, *American Doctors at the Nuremberg Medical Trial*, 1 AM. J. PUBLIC HEALTH 47, 48-49 (2018).

¹⁰ Evelyn Shuster, *American Doctors at the Nuremberg Medical Trial*, 1 AM. J. PUBLIC HEALTH 47, 47-48 (2018).

¹¹ *Supra* note 9.

¹² *Supra* note 10.

¹³ Furkhan Ali. et al, *Consent in Current Psychiatric Practice and Research: An Indian Perspective*, 4 INDIAN J PSYCHIATRY, 667, 669-670 (2019).

¹⁴ Evelyn Shuster, *American Doctors at the Nuremberg Medical Trial*, 1 AM. J. PUBLIC HEALTH 47, 51-52 (2018).

Association formulated ethical guidelines for medical research, famously referred to as the ‘Helsinki Declaration’¹⁵ in June 1964, in Helsinki, Finland. The declaration emphasised on the distinction between medical care that benefits the patient, and research that may/may not provide benefit. The Declaration’s original text had 11 principles, which was later increased to 36.¹⁶ The Nuremberg Code, combined with the Declaration of Helsinki, formed the basis for the Code of Federal Regulations issued by the United States Department of Health and Human Services for the ethical treatment of human subjects.

Informed consent – now universally accepted – constituted Article 7 of the United Nations’ International Covenant on Civil and Political Rights.¹⁷ This also served as the basis for the International Ethical Guidelines for Biomedical Research involving Human subjects, that had been proposed by the WHO, in association with the Council for International Organisation for Medical Sciences (CIOMS).¹⁸ In 1976, the National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research published the Belmont Report, which outlines the basic ethical principles that must be respected when conducting biomedical or behavioural research involving human subjects.¹⁹ The Belmont Report was founded on three governing principles — *first*, respect for participants; *second*, beneficence; and *third*, justice.²⁰ The 1964 Helsinki Declaration, and the International Ethical Guidelines by CIOMS are the ethical standards universally applicable and accepted in research today for informed consent.

The development of informed consent is well known, both in tort law as well as in common law jurisdictions, and has a natural, obvious relation to a person’s self-determination. In the previously mentioned *Schloendorff v. Society of New York*, the principle of autonomy was first established.²¹ The doctrine of informed consent – where the doctor is obligated to discuss alternatives to the treatment, consequences of no treatment, amongst others with the patient – can be traced to American jurisprudence, with jurists placing special emphasis on individual autonomy. In *Canterbury v. Spence*, 1971, the Court raised the question of whether the consent involved in that particular case was informed or not — it was held that if the patient’s consent is not obtained “properly”, that is if the consent has been given without proper understanding

¹⁵ Declaration of Helsinki: Ethical Principles for Medical Research involving Human Subjects, World Medical Association (1964).

¹⁶ *Supra* note 13.

¹⁷ Int’l Covenant on Civil & Political Rights, Dec. 19, 1996, art. 7.

¹⁸ *Supra* note 13.

¹⁹ Furkhan Ali. et al, *Consent in Current Psychiatric Practice and Research: An Indian Perspective*, 4 INDIAN J PSYCHIATRY, 667, 670-671 (2019).

²⁰ *Ibid*.

²¹ *Schloendorff v. Society of New York Hospital* 105 N.E. 92, 211 N.Y. 125.

of the risks, etc., of the treatment, then it can be considered to be a tort of battery against the patient.²² The ‘Prudent Patient’s Test’ was also first laid out in *Canterbury*, an assessment that decides if a patient is rational enough to decide their own course of treatment.²³

In the U.K, the standard of care was established in *Bolam v. Friern Hospital Management Committee, 1957* — essentially, what this judgement laid down in the form of the ‘**Bolam’s Test**’, is if the standard of care provided by the medical practitioner is question aligns with that of a similarly qualified and experienced doctor in similar circumstances, then the professional is said to have acted with due diligence.²⁴ Informed consent, which was initially acknowledged in the U.K. in *Sidaway v. Board of Governors of Bethlem Royal Hospital and Maudsley Hospital and Others, 1985*, upheld the Bolam’s test. Simply put, under this test, professional standards were set for professional conduct according to the standards displayed by the individual’s peers — if a doctor decides not to share certain sensitive information regarding the treatment to the patient because they believe it would do more harm than good, and if the same would have been done by a similarly positioned doctor, then the former cannot be sued for the lack of disclosure, that is, failure in obtaining informed consent²⁵. This is fairly in contrast with the position that the Court took in *Bolitho v. City and Hackery Health Authority*, where it was held that that a reasonable man can deviate from ordinary practice provided that the course of action they followed was logical — this was the ‘**Logical Test**’.²⁶

When it comes to determining medical negligence or informed consent, Indian Courts constantly jump between the tests established in Bolam and Bolitho. This is owing to the Indian scenario being incredibly haphazard — it moves between real and informed consent all the time. The Judiciary tends to lean towards real consent, but Courts differ on the same more often than not.

INFORMED CONSENT FOR THE MENTALLY ILL

We understand that there are two crucial points that are required for any consent to be considered valid — *first*, the person giving consent must be competent to do so; *second*, such consent must also be of the informed nature, that is, the consent is obtained after providing all

²² *Canterbury v. Spence* 464 F.2d. 772.

²³ *Ibid.*

²⁴ *Bolam v. Friern Hospital Management Committee* [1957] 1 WLR 583.

²⁵ *Ibid.*

²⁶ *Bolitho v. City and Hackney Health Authority* [1998] AC 232.

necessary information to the patient.²⁷ The purpose or intent behind such an expectation is to ensure that the patient is capable of weighing the risks and the benefits of the treatment being offered to them. Essentially, law presumes that the ability to do so is attained upon reaching the age of majority – which is 18, under Indian law²⁸ – and would then be able to give valid consent for any treatment.

Furthermore, law presumes capacity, autonomy and rationality if the person has attained the age of majority. However, if there is reason enough to believe that the patient is unable to understand the nature of the treatment, and all of its significant details, it becomes necessary to consider whether the adult presumption of capacity requires rethinking in that case. If the patient, for whatever reasons, is incompetent or incapable of giving consent, then such consent may be obtained from their legal representative, or their ‘proxy’.²⁹ Such incompetence may be the result of several reasons — perhaps the patient may not be fully conscious, or they are under the influence of alcohol or other intoxicating agents. Or perhaps, they may not be mentally sound.

Two observations were made by the Apex Court in the landmark judgment of *Samira Kohli v. Dr. Prabha Manchanda and Another* (2008), that is,

1. Consent will become real if the patient gives it voluntarily without any coercion, and
2. It can only be considered valid if the patient has the capacity and competence to give consent.
3. Lastly, for the consent to be held valid, the patient needs to have an adequate amount of information regarding the nature of the procedure.

Informed consent is crucial in Indian mental health care, as the Mental Healthcare Act, 2017 (hereinafter referred to as the ‘MHCA’) mandates the same in the admission, treatment, discharge *and* research intervention or procedures.³⁰ As per the MHCA, informed consent refers to, “*consent given for a specific intervention, without any force, undue influence, fraud, threat, mistake or representation, and obtained after disclosing to a person adequate information including risks and benefits of, and alternatives to, the specific intervention in a*

²⁷ Nandimath Omprakash V. et al, HEALTH LAW AND ETHICS — CRITICAL REFLECTIONS 221 (Bharat Law House, 1st edn. 2022).

²⁸ The Indian Majority Act, 1875, § 3.

²⁹ Nandimath Omprakash V. et al, HEALTH LAW AND ETHICS — CRITICAL REFLECTIONS 223 (Bharat Law House, 1st edn. 2022).

³⁰ *Supra* note 19.

language and manner understood by the person".³¹ Any mental illness, as specified under Section 3, should only be determined on the basis of nationally or internationally accepted medical standard, "*as may be notified by the Central Government*".³² Most relevant to the current topic is Section 4, which details a patient's **Capacity to make mental healthcare and treatment decisions** — every person, including those with a mental illness, shall be deemed to have capacity to make decisions regarding his mental healthcare or treatment so long as the person has the ability to, *firstly*, understand the information relevant to take such a decision; *secondly*, appreciate any reasonably foreseeable consequences of the treatment or the lack thereof; *thirdly*, communicate such decision by means of "*speech, expression, gesture or any other means*".³³ Merely because the person's decision may be considered or *perceived* by others as inappropriate or wrong, that by itself, shall not mean that the person lacks the capacity to make decisions for themselves with regards to their mental health.³⁴

In *re F* (1990), a House of Lords judgment, the matter revolved around the sterilisation of a mentally ill woman, who had had relations with a man in the asylum³⁵. She did not wish to continue with the sterilisation; however, since her doctors and caretakers were of the opinion that she would be unable to cope with the effects of pregnancy, they applied for a declaration that non-consensual sterilisation of the woman should not be held unlawful. The Court said that you can't obtain the capacity of the woman, as she had the mental capacity of a 4-year-old, and the verbal capacity of a 2-year-old — consequently, the House of Lords held that, since there is no chance of self-representation, the representative can take any decision that they believe to be beneficial to her.³⁶

Years after the above decision, English Court comes with another milestone judgment on an adult's right to refusal to treatment in *Re. C*.³⁷ The plaintiff, a chronic paranoid schizophrenia patient, seeks an order before the court that no amputation be done without his specific written consent. The group of doctors who were responsible for his treatment were divided in their opinion as to whether such life-saving amputation was needed at all, considering the patient's chronic paranoid schizophrenia. The Court had to evaluate the situation; before it lay the

³¹ The Mental Healthcare Act, 2017, §2(i).

³² The Mental Healthcare Act, 2017, §3.

³³ The Mental Healthcare Act, 2017, §4.

³⁴ The Mental Healthcare Act, 2017, §4(4).

³⁵ *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1.

³⁶ *Ibid.*

³⁷ *Re C (Adult: Refusal of Medical Treatment)*, (1994) 1 All ER 810.

questions of whether the Plaintiff's choice was directly influenced by his mental condition, or if he had taken such decision entirely of his voluntary choice.

An expert doctor, who had been called in by the Court, opined that there was no such direct link between his refusal and persecutory delusions (arising out of his medical condition). It was also explained to the court that, generally a patient's decision goes through three stages of processing — *first*, to take in and retain the information of the treatment; *second*, to believe it, and; *third*, to weigh that information, through balancing risks and needs. If the same were to be applied to Mr. C's case, he satisfies the first stage, but does not truly believe in the information being provided to him, thus choosing to refuse amputation. After due considerations, the Court granted the relief sought by Mr. C, stating the individual's autonomy would have to be respected even if the situation *was* life-threatening. This instance or judgment further emphasises that highest priority must be given to the individual's right of autonomy of choice.

CHILDREN AND INFORMED CONSENT

Law requires that an adult patient, who is mentally and physically capable of exercising choice, must consent, if the medical treatment sought to be administered to them is lawful. The question, however, arises — what if the patient in question *weren't* of adult years, *and* mentally capable of exercising such a choice. As per section 7.16 of the Medical Council of India (MCI) Regulations:

*“Before performing an operation the physician should obtain in writing the consent from the husband or wife, parent or guardian in the case of minor, or the patient himself as the case may be. In an operation which may result in sterility the consent of both husband and wife is needed”.*³⁸

The Supreme Court in *Samira Kohli v. Dr. Prabha Manchanda* emphasised that it is patient, and the patient alone, who is required to give consent for what they wish to allow to happen to their body, in terms of treatment — that is, *if* he is **competent** to consent.³⁹ The consent can't be obtained on the behalf of the patient from a guardian, parent or spouse, except when the patient is a minor — in such a case, the guardian or parent has all the rights to give or refuse

³⁸ Medical Council of India Regulations, Rule 7.16.

³⁹ *Sameera Kohli v. Dr. Prabha Manchanda & Another* 2008 (1) SCALE 442.

consent. An interesting point to be noted here is that there is also a place for additional assent of the minor themselves, if they pass the ‘**Mature Minor**’ test, established in *Gillick v. West Norflock and Wisbech Area Health Authority*.

The controversy at the heart of this judgment started with a response to the Department of Health and Social Security’s (DHSS) medical advisory issued to the doctors.⁴⁰ As per such advisory, doctors may provide contraceptive advice to a minor (under 16) under ‘exceptional circumstances’.⁴¹ Mrs. Victoria Gillick, outraged at the same owing to her being a mother of young girls, claimed the directive to have no legal standing. In the first instance, her contention was successful. However, upon further appeals, the House of Lords was prone to accept the DHSS’s arguments — the directive only gives doctors provide crucial contraceptive advice under ‘exceptional’ circumstances, and DHSS is compelled to address the hard, contemporary challenges.

One of the Lords, in his opinion, held that it was the House’s belief that such autonomy should be held by minors even apart from exceptional circumstances.⁴² Thus, the appeal was allowed, and it was held that there was no statutory provision that clarifies that a girl under 16 years lacks the legal capacity to consent to such contraceptive advice, *provided* that she has sufficient understanding and the intelligence to know what this would mean. Such ‘maturity’ is to be determined by the consulting physician, and if the minor were to pass it, it will be their consent that should be considered, not the parent.

Considering this, it is time to shift to the approach of the Indian Courts on this matter. However, the point we need to start with is that there is no direct litigation on this particular point of law.⁴³ Moreover, the aforementioned Rule 7.16 requires the physician to obtain the consent of the parent/guardian if they dealing with a minor — it gives no mention to a situation where a minor has attained enough maturity to understand the consequences of their choices. It is interesting to note that, even in the case of *Gillick*, there was the Family Reforms Law, which prioritised parental authority over the minor. This prescription of law was, as we saw it, diluted by the judgment of the House of Lords. What the Supreme Court may do if such a case were to find its way into the court systems is anyone’s guess; however, it is safe to say that, as of

⁴⁰ *Gillick v. West Norflock and Wisbech Area & Department of Health and Social Security* [1986] AC 112.

⁴¹ *Ibid.*

⁴² *Supra note 40.*

⁴³ Nandimath Omprakash V. et al, HEALTH LAW AND ETHICS — CRITICAL REFLECTIONS 248 (Bharat Law House, 1st edn. 2022).

now, the law only allows for the parents or guardians to consent on behalf of the minor, and the doctor has no authority to breach that authority.⁴⁴

ANALYSIS/RECOMMENDATIONS

The decision-making capacity of a person with a mental illness can be coloured or affected due to certain factors such as psychopathology, insight about illness and the cognitive dysfunction.⁴⁵ The presence of a delusion (such as persecutory delusion or nihilistic delusion) might influence his decision-making. However, as we have seen, all patients taking psychiatric treatment are not fully incompetent to give consent. Several patients, even those with major mental disorders can understand and provide consent at times.⁴⁶ The main barriers to informed consent are lack of reasoning and understanding — which would imply the patient's impaired capacity. Therefore, if the consent process is tailor-made to overcome these deficits, it becomes more meaningful and practicable in clinical settings. When patients do not have the mental capacity, it is sometimes needed to use ethical values to act in the best interest of the patients. However, unless evidence to the contrary, the patient's capacity to make an informed decision must always be presumed, and the onus of proving otherwise falls upon their mental health professional to prove otherwise — this is the stance of the MHCA. First priority must always be given to the patient's right to self-determination and autonomy.

In India, there is no inclusion or incorporation of the 'Mature Minor's' test — full power and choice is given to the parent/guardian, which poses a moral problem when the minor's consent (arrived at through careful consideration of the options laid before them) differs from that of the parent. In situations where the doctor has already obtained the consent — for or against a procedure — from the parent/guardian, it would be advisable for him/her to talk to the minor involved as well, on the nature of the procedure, its risks, pros, cons, et cetera. This would be a comfort to the minor, and also offers a chance for the doctor to gauge their opinion towards the procedure — whether they are in agreement with their parents/guardian or not. The situation naturally becomes tricky if the minor disagrees with the consent of their guardian.

⁴⁴ Nandimath Omprakash V. et al, HEALTH LAW AND ETHICS — CRITICAL REFLECTIONS 249 (Bharat Law House, 1st edn. 2022).

⁴⁵ *Supra* note 19.

⁴⁶ S.N. Deshpande et al, *Informed Consent in Psychiatry Outpatients*, 1 INDIAN J. MED. RES. 35, 40-41 (2020).

It would be best if the doctor assesses the maturity level of the minor and delay the procedure – considering that it is not an emergency – until further counselling. However, the minor's opinion would have no sway in an emergency, but this is the case for all individuals, as was held in [...]. If a 'mature' minor has come for an elective procedure, without their guardian, it might be advisable for the doctor to take such guardian into confidence – over the phone or otherwise – if the minor does not mind the same. However, if the minor does have an objection with discussing the matter with their guardian, what the doctor must do next is an open question. Whether the doctor, in an attempt to uphold the right to self-determination and autonomy of the mature minor, should go ahead with the procedure, is a question that needs to be answered.

If such a case were to appear before the Courts, judicial scrutiny in such a situation will require assessing several factors such as the nature of the procedure, whether it was necessary or not, why the minor doesn't want the parent/guardian to know, and last but not least, the maturity level of the minor. There is no precedent for the same, and the final word on it has still not been written in India.⁴⁷ This paper recommends that, in the case a minor (who has passed the 'Minor's Test' as laid down in *Gillick*) disagrees with their parent/guardian in terms of the course of procedure, the Court prioritise the minor's opinion on what is to be done with their own body, as everyone who is capable of making an informed decision should have the choice to informed consent.

CONCLUSION

The doctrine of informed consent has become incredibly important in the practice of healthcare today, owing to the fact that the public is growing more aware of its right to autonomy when it comes to decisions about their own body. Consequently, hospitals and medical practitioners have taken to documenting the discussion between the doctor and the patient that takes place before consent is given. A large percentage of medical litigations revolve around consent, and such consent is even trickier when it comes to people who are typically not thought of as having the capacity to consent. It becomes crucial, therefore, to have clear concepts and ideas about this doctrine and to implement it in medical practice correctly. This, however, is a problem in India because, when it comes to the case of those who are mentally ill or minors, the law provides for very little nuance when it comes to determining if the patient can still understand,

⁴⁷ *Supra* note 44.

and consent to their treatment without any representative, guardian or parent. This, thus, needs to be rectified.