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ORIGINAL PAPER

The Rhetoric of the 'Passive Patient' in Indian Medical Negligence Cases

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Abstract

In this paper, I examine the rhetoric employed by court judgements, with a particular emphasis on the narrative construct of the 'passive patient'. This construction advances and reinforces paternalistic values, which have scant regard for the patients' preferences, values, or choices within the legal context. Further, I critique the rhetoric employed and argue that the use of this rhetoric is the basis for a precedent that limits the understanding and respect of patients. Through this paper, I present the contemporary use of the 'passive patient' construct in the context of the Indian legal system and describe how such constructions have become a source of normative justification for legal reasoning that jeopardizes the patient's agency. I argue for the primacy of 'respect for persons' within Indian law and the need to treat each patient as a *person* who has agency, preferences, and values during clinical interactions. I conclude by suggesting that laws that adopt narratives that acknowledging the significance of patient engagement and the relevance of effective communication during clinical encounters would help cultivate a culture of patient-centred care, by moving beyond the rhetoric of 'passive patient' and the 'health/choice' dichotomy.

Keywords Respect · Agency · Law · India · Patient-centred care · Consent

Introduction

The need to shift from a paternalistic approach to a patient-centred approach for both clinical practice and law has been well-recognized within the bioethics, medico-legal, and health services research literature (Brazier and Miola 2000; Edozien 2015; Saha et al. 2008; Brazier and Lobjoit 2005; Groll 2014; Manson and O'Neill 2007; Macklin 1999; Entwistle et al. 2010). This shift can be achieved through the recognition of

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specific concepts, such as autonomy, self-determination, person-/patient-centred care, dignity, and human rights. In the bioethics and medico-legal literature, particularly during medical decision-making contexts, the concepts of 'patient autonomy' and 'self-determination' have been widely recognized as being necessary to avoid paternalism and to protect the patients' autonomous choices. One method for protecting autonomous choices would be to uphold the doctrine of 'informed consent', which is based on the philosophical idea of 'respect for autonomy' (Beauchamp and Childress 2013; Faden et al. 1986; Faden et al. 1981; Berg et al. 2001). These concepts are based on liberal 'world views' and the characterization of patients as competent adults who are capable of making their own decisions. Thus, the presumed concept of a *patient* in most of these discussions is that of a 'competent adult, who can make autonomous choices'.

Although patient rights, patient-centred care, and autonomy debates have been well-received, through multiple efforts focused on moving away from paternalism during both law and clinical practice reforms, a persistent asymmetry remains during clinical interactions. These studies observe lack of 'patient engagement', where healthcare professionals do not acknowledge patients' values or preferences and do not treat patients and family members with respect and dignity (Subramani 2018, 2017; Frosch et al. 2012; Pilnick and Dingwall 2011). The persistence of asymmetry during clinical interactions, which prevent the practice of patient-centred care and sustain paternalism and disrespectful attitudes, are often caused by the limited availability of resources, including human resources, and time, implicit biases, and socio-economic factors (Willems et al. 2005; Van Ryn and Burke 2000; Subramani 2018; Pilnick and Dingwall 2011; Blumenthal-Barby 2017). However, the fundamental *assumptions* that these debates rely on are often neglected. In this paper, I examine the assumptions built into current laws, based on rhetoric and the narratives that form particular 'world views' regarding patients and doctors, that sustain the power asymmetry within doctor-patient relationships. I intend to illustrate how pervasive paternalistic values, expressed through the rhetorical construct of 'passive patients' in legal reasoning associated with Indian medical negligence cases, inhibit the acknowledgement of the patients' *agency* or denying their abilities to have preferences and values. To achieve reform within the law, the critical understanding of assumptions and constructions that influence judicial decision-making processes is necessary (Frohmann and Mertz 1994; White 1985; Roach Anleu 2000; Ehrlich and Ziegert 2001; Rosenberg 1993; Bourdieu 1987). Therefore, I shall focus on the rhetoric within the law to illustrate how a 'patient' is defined through the adoption of specific legal reasoning (White 1985; Hasian et al. 1996; Wetlaufer 1990). Although global bioethics debates have established that doctors and health professionals are ethically and legally obligated to recognize patients' values, preferences, and choices and to validate patients as agents who have both the 'capacity' and 'ability' to make their own decisions, in this paper, I argue that this rhetoric has failed to resonate within the law, particularly within the Indian legal context. An examination of medical negligence cases revealed two major constructs: 'passive patient' and 'doctor knows best' (Subramani 2019).[1] This rhetoric advances

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[1] One of the objectives of my doctoral study was to analyze Indian medical negligence cases, particularly consent cases, to understand the underlying ethical and legal values and principles of 'consent'. I had employed critical legal hermeneutic method along with textual content analysis (Danelski 1965; Dworkin 1986; Elo and Kyngäs 2008; Hsieh and Shannon 2005; Moloney 2001). More details of the analysis are provided in Subramani (2019).

the paternalistic views regarding the respective roles of doctors and patients and limits patients' agency, values, and choices in the context of Indian medical negligence cases.

I consider law not only to reflect legal rules and policies but also to tell stories and provide explanations; thus examining the narratives and rhetorical reflections built into the constructions that are embedded in legal judgements capture the stories and explanations meant to reflect legal rules and policies (Brooks and Gewirtz 1998; Hunter and Cowan 2007; White 1985; Wetlaufer 1990). Drawing on previous rhetorical studies (Jackson 1996; White 1985; Hunter and Cowan 2007; Ehrlich and Ziegert 2001; Charland 1987) and employing constructivist interpretive framework (Schwandt 1998; Charmaz 2006), I attempted to explore the socially constructed narrative of presumed assumptions within court judgements. By understanding that law draws from and contributes to our understanding of the moral premises of a given culture, the narratives and rhetoric within landmark judgements are appropriate sites of inquiry because they provide a view of the preferred dominant values. Furthermore, as Charland (1987) and Roach Anleu (2000) have argued, the court's opinion has real consequences and implications. Court judgements are significant for medico-legal debates and medical ethics because they often include concepts or images of the 'patient' that become part of the rhetorical framework of reasoning, such as during debates about patient rights. Recently, some studies have focused on how a 'patient' is framed during healthcare law debates, particularly in English courts (Montgomery 2017; Purshouse 2018; Montgomery and Montgomery 2016; Heywood 2015). The formulations in law, through the moral and legal significance that they convey, can endorse certain notions regarding the society they draw from and contribute to the public rhetorical culture (Hasian et al. 1996; White 1985; Charland 1987). In this paper, I will capture the constructed narratives that refer to evaluative judgements, based on the learned judges' perceptions, values, and presumed understandings. Through this process, I will illustrate how the dominant rhetorical arguments and narratives are created and sustained within the legal reasoning. Drawing upon the existing literature that has examined assumptions regarding 'patients', the persistence of asymmetry during doctor-patient interactions, and patient-centred approaches, I will explore the dominant rhetoric currently expressed in the Indian legal context and discuss its implications.

This paper is divided into two major sections. In the first section, I have included excerpts from a landmark judgement of the Supreme Court of India, Samira Kohli vs. Dr. Prabha Manchanda (2008), to present the dominant narratives and rhetoric found in court judgements associated with medical negligence cases in India and their implications. By exploring these narratives, I present how these constructions have become the source for normative justifications of legal reasoning, which jeopardizes patients' agency. In the second section, I argue for the primacy of 'respect for persons' within the law in the Indian setting and for the need to recognize each patient as a 'person' and an 'agent' who has preferences, by moving beyond the notion of 'doctor knows best'. I conclude this paper by suggesting that a legal narrative that acknowledges the significance of 'patient engagement' and the relevance of 'effective communication' during clinical encounters, will cultivate a culture of 'patient-centred care' within the persistently asymmetrical healthcare system, by moving beyond the rhetoric of 'passive patients' and the false dichotomy between physical health and patient choice.

The Mandate of 'Patienthood'

Before examining the rhetoric that informs court judgements of medical negligence cases in India, I will briefly discuss the context surrounding these narratives. Many studies have established that asymmetry exists in the doctor-patient relationship, including larger social inequalities, and have examined the nature of clinical interactions to suggest various methods for achieving patient-centred care (Entwistle et al. 2008; Smith-Oka 2015; Makoul and Clayman 2006; Ishikawa et al. 2013; Schermer 2002; Roter 1977; Freidson 1970; Subramani 2018). Few scholars question the persistence of this asymmetry during clinical interactions, and some have suggested that the phenomenon of asymmetry should be viewed as a function of social and organizational embeddedness (Pilnick and Dingwall 2011; Heritage and Maynard 2006; Parsons 1951, 1975; Bunn 2011). Further, scholars have suggested that this asymmetry is indicative of the exercise of power and existing medical authority, suggesting that medicine is a normative order-maintaining enterprise that results in patients exhibiting 'sick role' and 'illness behaviour' (Parsons 1975; Collyer 2018; Roemer 1960). Other studies have questioned the phenomenon of 'sick role' because it 'advocated conformity and passivity and denied the importance to individual agency' (Burnham 2013; Young 2004).

The reference to the 'patient role' is based on the perceptions, assumptions, the existing asymmetry of the doctor-patient relationship, and the resistance to paternalism, and the embrace of patients' rights has been observed within court judgements. For example, an excerpt from Lord Bridge's judgement in the Bolam case (as cited in Samira Kohli's case) illustrates this narrative and juxtaposes American and British standpoints regarding consent to treatment and information disclosure debates.

> I recognize the logical force of the Canterbury doctrine, proceeding from the premise that the patient's right to make his own decision must at all costs be safeguarded against the kind of medical paternalism which assumes that 'doctor knows best'. But, with all respect, I regard the doctrine as quite impractical in application (p. 13).

The patient as 'passive', 'ignorant', 'helpless', and 'vulnerable' and of the doctor's role as restoring 'health' in the 'best interests of patients' has been observed and discussed in the context of both clinical practice and the law (Hunter and Cowan 2007; Secker 1999; Smith-Oka 2015; Montgomery 2017; Montgomery and Montgomery 2016; Mocherla et al. 2011; MaClean 2005). Amsterdam and Burner (2002) stated,

> familiarity is dulling—that when our ways of conceiving of things become routine, they disappear from consciousness and we cease to know *that* we are thinking in a certain way or *why* we are doing so…to make the familiar strange again, to rescue the taken-for-granted and bring it back into mind…The practice of law is full of such dissociated routines, of canonical ways of proceeding 'scarcely worth a moment's thought' (p. 1).

With this background, now I turn to the law, to examine the dominant narratives and rhetoric found in court judgements to examine the pervasiveness of roles and assumptions associated with the mandate of expected 'patienthood', which is discursively constructed. In the next section, I will provide brief background information for Samira Kohli vs. Dr. Prabha Manchanda (2008), as this case represents the current precedent case that is referred to during medical negligence cases associated with consent and information disclosure issues. In this case, the construction and image of a 'patient' played a significant role in the legal reasoning. I will then present the dominant rhetoric and narratives surrounding the concept of 'patients' during doctor-patient relationships and clinical interactions, in the Indian context.

The Samira Kohli Case and the Concept of a 'Patient'

The idea of autonomy is one of the central moral justifications currently discussed in bioethics debates regarding the transition away from paternalism, and informed consent plays a significant role in respect for autonomy and the autonomous choices of patients (Bullock 2018; Beauchamp and Childress 2013). As mentioned in the "Introduction" section, the underlying concept of a patient in these debates is that of a 'competent adult who can make autonomous choices'. In law, the self-determination of an individual is based on this concept of a patient. Given this background, I use the Samira Kohli vs. Dr. Prabha Manchanda (2008), case to explore the concept of a patient in Indian court judgements, while engaging in the concept of consent, to illustrate how these ideas influence the legal reasoning. The *Samira Kohli* case is the first case that explicitly discussed 'real or valid consent', based on the English court's *Bolam* case,[2] and it has been adopted as the basis for Indian medical negligence cases (Subramani 2017). To date, this case remains the precedent for medical negligence and consent cases. Samira Kohli, a 44-year-old unmarried woman, consulted Dr. Manchanda, complaining of prolonged menstrual bleeding. The doctor removed the patient's uterus (abdominal hysterectomy), ovaries, and fallopian tubes (bilateral salpingo-oophorectomy), without obtaining a specific consent from the patient. The Supreme Court held the doctor guilty of negligence and allowed Rs. 25,000, as compensation to the victim. I have elsewhere discussed and critiqued this case, in detail (Subramani 2017).

In this case, the judgement not only provided details regarding the specific consent that should be obtained before surgery but also elaborated on the meaning of consent and the nature of information disclosure that should be adopted in the Indian context. These guidelines were based on preceding cases from the UK (as cited in the Samira Kohli case): Bolam vs. Friern Hospital Management Committee 1957 and Sidaway vs. Board of Governors of the Bethlem Royal Hospital 1985. The judgement consciously preferred the concept of 'real or valid consent', which evolved during the *Bolam* case, in contrast with 'informed consent', which emerged in the American *Canterbury* case. This decision was made with reference to the 'ground realities' of healthcare in India.

During bioethics and legal debates, the preferred consent test is based on the patient standard, and physicians are obligated to facilitate the patients' requirements for informative materials prior to making a decision. Here, the patients' rights for self-decision shape the boundaries of the duty to reveal (Faden et al. 1986; Maclean 2009;

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[2] For further detailed understanding of the Bolam test for consent discussions, refer to Brazier and Miola (2000), Maclean (2004, 2009) and Brazier and Cave (1992).

McLean 2010). In the *Bolam* case, from the UK, the concept of consent and information disclosure was based on the 'medical professional standard'. This decision has been recently overturned in the 2015 *Montgomery* case, which departed from the long-held position of a reasonable body of medical opinion and recognized that the values of patients should be acknowledged; thus, the test for material information disclosure is based on either a 'reasonable person' or the 'particular patient'. Although some scholars have argued that this standard emphasizes patient autonomy over medical paternalism and view it as a welcome development (Edozien 2015; Farrell and Brazier 2016; Foster 2015), others have critically disputed this emphasis (Dunn et al. 2018; Montgomery and Montgomery 2016). The debates regarding 'informed consent' within both the law and clinical practice, including the standards for information disclosure, appear to be never-ending due to the nuances and complexities associated with this idea; however, these debates have drawn my attention to the construction of a 'patient'.

Landmark cases, such as *Bolam*, *Sidaway*, *Montgomery*, *Schloendorff*, *Canterbury*, *and Rogers*, have influenced the setting of standards and have contributed to the conceptual development of 'consent' in medico-legal debates. I observe that the fundamental assumptions and concepts that surround 'patients' and 'doctor-patient relationships' have significantly influenced the push for certain concepts and standards in legal debates. Thus, the concept of a 'patient' that can be found in court judgements and in judges' narratives plays a significant role within the legal context and can cause a paradigm shift within both legal and bioethical debates. Therefore, in the next section, I closely examine the narratives and constructs surrounding 'patients', which have influenced the adoption of the 'medical professional standard' in Indian medical negligence cases, especially in the context of consent to treatment and information disclosures. By uncovering the narratives and rhetoric that affect the legal reasoning, I intend to identify the default concepts that must be changed to perpetuate specific values during legal reform.

The Rhetoric of the 'Passive Patient' and in the 'Best Interests of the Patient'

Compared with the validation of patients as 'agents' who have the 'right' to be informed regarding treatment decisions, as individuals who have 'ability' to be part of medical decision-making, and as 'right holders' in the bioethics literature, I state that this narrative has failed in Indian court judgements. An examination of the judicial reasoning expressed in the *Samira Kohli* case reveals two dominant constructs, which also permeate other contested consent cases: the 'passive patient' and the 'best interests of the patient'. These constructs are central to judgements that employ the 'medical framework' to clinical interactions, consent, and information disclosure issues in the Indian context, where physical health and bodily integrity are given significance (Subramani 2017). In Samira Kohli's case, the justification for the application of the *Bolam* test or the medical professional standard with regard to consent to treatment and information disclosure references the 'ground realities' of India, represented by poverty, illiteracy, and the respect and trust shown to doctors. The below excerpt illustrates this explicitly:

> (26) In India, majority of citizens requiring medical care and treatment fall below the poverty line. Most of them are illiterate or semi-literate. They cannot

> comprehend medical terms, concepts, and treatment procedures. They cannot understand the functions of various organs or the effect of removal of such organs. They do not have access to effective but costly diagnostic procedures. Poor patients lying in the corridors of hospitals after admission for want of beds or patients waiting for days on the roadside for an admission or a mere examination, is a common sight. For them, any treatment with reference to rough and ready diagnosis based on their outward symptoms and doctor's experience or intuition is acceptable and welcome so long as it is free or cheap; and whatever the doctor decides as being in their interest, is usually unquestioningly accepted (p. 13).[3]

In addition to the narrative of poverty and illiteracy, a larger narrative demonstrates the prejudicial concept of 'individuals' who get 'free or cheap' service and that do not ask questions about because they have 'implicit faith' in doctors who decide in their 'best interests'. The judgement stated:

> They are a passive, ignorant and uninvolved in treatment procedures. The poor and needy face a hostile medical environment - inadequacy in the number of hospitals and beds, non-availability of adequate treatment facilities, utter lack of qualitative treatment, corruption, callousness and apathy. Many poor patients with serious ailments (e.g. heart patients and cancer patients) have to wait for months for their turn even for diagnosis, and due to limited treatment facilities, many die even before their turn comes for treatment. What choice do these poor patients have? Any treatment of whatever degree, is a boon or a favour, for them. The stark reality is that for a vast majority in the country, the concepts of informed consent or any form of consent, and choice in treatment, have no meaning or relevance (p. 13).

Here, 'they' refers to patients, describing a broad view of individuals who are perceived as 'passive, ignorant, and uninvolved' in the decision-making process. This perception is justified by socio-economic and cultural contexts and the understanding of an inherently asymmetric doctor-patient relationship. In the judgement, another major narrative is that 'there is a need to keep the cost of treatment within affordable limits. Bringing in the American concepts and standards of treatment procedures and disclosure of risks, consequences and choices will inevitably bring in higher cost-structure of American medical care' (p. 15). The judgement stressed the 'scare resource' context to justify why the 'American view' cannot be adopted within the Indian context. The below excerpt reflects the rhetoric of 'Indian patients' who have 'implicit faith and trust' in doctors along, with a reference to the larger narrative of a 'noble' profession that demonstrates 'care'.

> Patients in India cannot afford them. People in India still have great regard and respect for Doctors. The Members of medical profession have also, by and large, shown care and concern for the patients. There is an atmosphere of trust and implicit faith in the advice given by the Doctor. The India psyche rarely questions or challenges the medical advice. Having regard to the conditions obtaining in

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[3] All the excerpts are from Samira Kohli vs. Dr. Prabha Manchanda (2008), case, MANU/SC/0430/2008.

> India, as also the settled and recognized practices of medical fraternity in India, we are of the view that to nurture the doctor-patient relationship on the basis of trust, the extent and nature of information required to be given by doctors should continue to be governed by the Bolam test …It is for the doctor to decide, with reference to the condition of the patient, nature of illness, and the prevailing established practices, how much information regarding risks and consequences should be given to the patients, and how they should be couched, having the best interests of the patient (p. 15).

The above excerpt capture the larger narratives of 'passive patients' and 'best interests of the patients' that are used to justify the legal reasoning and standards adopted within the Indian legal context. The central theme of *Samira Kohli* was the apotheosis of the 'doctor' by rhetorically constructing the 'passive patient', which was ascribed to the 'ground realities' in the Indian context. The significant narrative of the judgement revolved around the socio-economic conditions, the 'noble' profession of medical doctors, and the significance of nurturing the doctor-patient relationship, based on 'implicit trust'. The law constructs narratives that are presented as authoritative; therefore, in this judgement and those associated with other medical negligence cases, the lengthy narrative and rhetoric surrounding the significance of the doctors' roles and the nobility of the medical profession reflect the desire to increase the acceptance of 'medical authority' because doctors are viewed as 'professional experts' in the court of law. The references to 'doctor knows best' or doctors acting in the 'best interest of patients' are rhetorically conflated to support the use of the medical professional standard, which consider the doctor to be better suited to make medical decisions than patients, and the construction of the 'passive patient' does not provide patients with any role during the process. The below excerpt demonstrates how the judicial reasoning justifies the constructed narrative of the 'passive patient', who does not have any agency during decision-making processes and adheres to the larger concept of 'medical authority', in which the doctor always acts in the best interests of the patient. This excerpt also reflects the underlying moral judgements being made by the judge/s, who justifies the doctor's concept of a 'patient'. Furthermore, the statements provide insight into the commonly held 'stereotypical' understanding regarding the status of being an 'unmarried woman' of a particular age and how that affects authority regarding her body and choice.

> The respondent did it in the interest of the appellant. As the appellant was already 44 years old and was having serious menstrual problems, the respondent thought that by surgical removal of uterus and ovaries she was providing permanent relief. It is also possible that the respondent thought that the appellant may approve the additional surgical procedure when she regained consciousness and the consent by appellant's mother gave her authority. This is a case of respondent acting in excess of consent but in good faith and for the benefit of the appellant. Though the appellant has alleged that she had to undergo Hormone Therapy, no other serious repercussions is made out as a result of the removal. The appellant was already fast approaching the age of menopause and in all probability required such Hormone Therapy. Even assuming that AH-BSO surgery was not immediately required, there was a reasonable certainty that she would have ultimately required the said treatment for a complete cure (p. 23).

The above excerpt illustrates the construction of the ‘patient’, which is based on set prejudices within a particular context and the concept of the doctor-patient relationship, in which the patient is not given any ‘agency’ or ‘choices’ during the decision-making process. For instance, the judge justified the actions of the doctor as having been performed in ‘good faith and [for the] benefit’ of the patient because the patient was a 44-year-old woman and did not require a uterus, based on the cultural presumption that women of that age do not require the uterus. Although the specific consent to additional surgery has been recognized to within the context of ‘real or valid consent’, the rhetoric in this judgement describes a doctor who acted based on the ‘best interest of the patient’ for the ‘better’ health of the patient. Further, the above excerpt also captures the ultimate authority granted to the medical doctor over his/her patient’s body and the assumptions made in the judgement that do not consider the patient’s choices or preferences for her body. This landmark judgement defends the doctor’s role and authority, as well as the ‘implicit faith’ in medical professionals, by downplaying the role of the patient’s choices or values, and justifies this defence by citing the ‘ground realities’ within the Indian context. The concluding remarks of the judgement do not engage with or reflect on patients’ rights or patients’ preferences, values, and choices. Instead, the judgement empathizes with the doctor and affirms the moral regime of ‘doctor knows best’, assuming that the doctor acted in the ‘best interest’, regardless of the values or choices of the patients. The significance of this medical authority over patients is that it establishes patients as being ‘passive’ as not having the ‘ability’ to take part in medical decisions. The judgement does not consider or engage with patients’ values, preferences, and choices with regard to consent for treatment or information disclosure when it narrows the understanding of ‘information disclosure’ to the jurisdiction of medicine, which limits the role of the patient and his/her values. The rhetorical focus of ‘doctor knows best’ or that doctors act in the ‘best interests of the patient’ because the doctor represents the authority for medical knowledge and is necessary for the ‘better health’ of the patient, removes the patient’s authority and redefines the role of the patient as ‘passive’ within the medical decision-making process. The portrayal of the ‘passive patient’ silences the patient’s stories, values, preferences, and choices, which should instead be considered during the medical decision-making process.

Construction of the ‘Passive Patient’: Justifying the Denial of ‘Agency’

The Samira Kohli judgement provides a rich understanding of the concepts of the ‘patient’ and patients’ rights that are expressed in court judgements. The constructed ‘patient’ within the law is the product of legal reasoning and justification, and the analysis of the narrative and rhetorical properties in judgements can provide an unseen judicial opinion (Amsterdam and Bruner 2002). As White (1985) suggested, the analysis of legal judgements involves unpacking the rhetorical meanings that are created through the political and ethical assessments of the context. Although the language of patients’ rights has been used to deploy the doctrine of ‘real or valid consent’ within the Indian context, uncovering the rhetorical meaning within the judgement suggests that the court instead advances the understanding of ‘medical authority’ and the ‘passive patient role’ within the medical decision-making context.

The court's approach privileges the 'medical authority' by focusing on the 'health' of the patient as the fundamental role of medicine, removing the patient's values, preferences, and choices from the decision-making process. Consequently, the rhetorical choices and narratives found in the judgement have profound symbolic effects on the concept of the 'patient'. The philosophy of 'doctors know best' and the characterization of 'passive patients' as unquestioning individuals reveal an understanding of patients who are 'incapable' decision-makers. Rather than treating patients as 'agents' who are independent decision-makers within the medical framework, the rhetoric of 'medical authority' figures acting in the 'best interests of the patient' to protect the 'health' of the patient is established in the court judgement, which also reaffirms the patients' 'socio-economic conditions' and the role of 'better health' as reasons not to focus on the values of the 'patient'.

The rhetoric in *Samira Kohli* advances the dichotomy of the 'health/choice' approach to patient rights, where the focus is explicitly placed on 'physical/bodily health' by recognizing 'bodily integrity' by requiring specific consent to additional surgeries while simultaneously displacing the values, preferences, and choices of the patient away from bodily integrity (Subramani 2017). The concept of bodily integrity in Indian law can best be understood as 'a right to be free from physical interference', which was stated in Feldman's magnum opus, *Civil Liberties and Human Rights in England and Wales* (Feldman 1993, p. 241). This concept covers negative liberties, including 'freedom from physical assaults, torture, medical or other experimentation, immunization and compelled eugenic or social sterilization, and cruel or degrading treatment or punishment. It also encompasses some positive duties on the state to protect people against inference by others' (Feldman 1993, p. 241). Here, I distinguish the concept of 'bodily integrity' from the concept of 'bodily autonomy', wherein the latter emphasizes the exercise of choice or decisions. In case law, within the Indian context, information disclosure is based on medical standards, and the culpability for negligence is established through deficiencies in service (physical/bodily harm). The guidelines provided in the *Samira Kohli* judgement regarding the 'adequate information' disclosure, the decision to apply the *Bolam* test, and the acceptance of the UK doctrine of real or valid consent during consent cases related to information disclosure reflect the dominance of the professional standard of disclosure. Thus, through this analysis, we can understand that the 'real or valid consent' doctrine is a tool that only protects 'physical body'. Protection from physical harm based on medical professional standards is considered to be the ultimate protected interest and not the patient's requirements for information, indicating that the basic source for the legal principle of 'real or valid consent' is bodily integrity, in the Indian context. The patient's entitlement to material information is not given utmost significance when bodily harm has not been established, based on medical professional standards.[4] This demonstrates that patients' receipt of material information depends on the physician's information disclosure standard, which reflects that the patients' right to all pertinent information does not play a significant role within the legal doctrine.

Although the scholarship associated with autonomy, self-determination, and patient rights has advanced over the decades, the legal reasoning in India identifies and

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[4] Analysis based on 22 medical negligence cases which had referred to the Samira Kohli case. Further details in Subramani (2019).

constructs the dominant identity of the ‘passive patient’ within the medical framework, overlooking the intrinsic significance of patients’ values and preferences. The reasoning is normatively justified based on the rhetoric of ‘doctor knows best’, along with consideration for ‘Indian ground realities’, including ‘poverty’, ‘not to increase cost of treatment’, ‘better health’, ‘respect for doctors’, ‘trust’, and ‘implicit faith’. By applying the *Bolam* principle, combined with the belief that medical professionals act in the ‘best interests to the patient’ and the construction of the ‘passive patient’ through rhetoric and narratives, the judgement overlooks the patient’s values, preferences, choices, and requirements for information during clinical interactions. Thus, patients’ capacity to make decisions is underestimated, and their ‘agency’ is disregarded. The statements in the judgement beg the following questions. Can we deny the role of patients’ values, preferences, choices, and requirements for information because the population of a country is poor and illiterate and trusts medical professionals? Do being poor and illiterate mean that a person ‘cannot’ make decisions, have ‘choices and values’, or participate in medical decision-making process? Let us assume that valid generalizations and social facts exist to support the claims that ‘Indian patients’ cannot make medical decisions; does it follow that their values and preferences, and right to participate in clinical interactions should not be acknowledged? These questions demand further study. Given the scope of this paper, in the next section, I will restrict my argument to a narrative that would acknowledge the values and preferences of patients and that would recognize them as being active participants within a legal reasoning focused on patient-centred care through legal reform.

‘Respect for Persons’ as the Way Forward: a Narrative Towards ‘Patient-Centred Care’

Although some scholars are sceptical of the judicial influence over society, I make my arguments based on the consideration that the Supreme Court has historically played a critical role in transforming social concepts and influencing policy debates (Rosenberg 1993; Anthony and Jerome 2001; Vecera 2014; Mishler and Sheehan 1993; Scheingold 2010). Furthermore, evidence suggests that courts intensify national attention on policy issues (Flemming and Dan Wood 1997; McGuire and Stimson 2004; Kostiner 2003). Many legal scholars who focus on the attitudinal models of judges have highlighted that court decisions are made based on the ‘case facts vis-à-vis their sincere ideological preferences and values’ (Segal 1997: p. 28; Segal and Cover 1989). Given this understanding, I argue that a paradigm shift in the concept of a ‘patient’ as a ‘person’, who is an active participant in decision-making processes, and a focus on effective communications within court judgements would have a strong influence to push for the culture of ‘patient-centred care’ in society. I, here, refer to the meaning of patient-centred care as ‘respectful of and responsive to individual patient preferences, needs, and values’ (Epstein et al. 2010), during clinical interactions. Many studies have established that patient-centred care improves both health outcomes and overall healthcare (Elwyn et al. 2014a; Barry and Edgman-Levitan 2012; Tinetti et al. 2016; Elwyn et al. 2014b; Mead and Bower 2000). Specifically, patient-centred care improves healthcare by reducing social, economic, and demographic differences between doctors and patients and encouraging doctors to become aware of their patients’ values, beliefs, hopes, and other concerns (Willems et al. 2005; Beach et al. 2005; Saha et al. 2008; Beach et al. 2007; Rao et al. 2007).

In this patient-centric approach, the focus is on facilitating the patients' understanding of information, instead of disregarding them as persons who 'cannot' understand or make decisions. In bioethics and philosophical literature, the perception tends towards patients to be treated as 'persons' (Devaney 2005; Brazier and Lobjoit 2005; Entwistle and Watt 2013; Beach et al. 2007; Dickert 2009), which has been justified by various scholars, based on the various positions and values that they hold (Entwistle and Watt 2013; Lysaught 2004). In this paper, I situate the 'respect for persons' concept by extending the larger understanding to a 'person' who must be treated with respect because they are agents who have values and preferences, which should be acknowledged within the legal context. The rhetoric and construction of a 'passive patient' within the court's medical framework upholding 'medical authority' provides normative justification for adopting the 'medical professional standard' within the Indian context. The implication of the rhetoric is as follows: patients are not considered to be 'agents' or 'persons' who have values and preferences.

Although established consensus exists in both medico-legal and bioethical literature that adult patients should be presumed to be competent and allowed to be decision-makers, unless rendered clinically or legally 'incompetent', I have demonstrated that, within the law in India, 'passive patients' have been constructed and deemed to be persons who do not have the ability to make decisions or be part of the decision-making process. According to legal and ethical literature, a person is competent if he or she is capable of understanding consequences and has the ability to make choices (Grisso and Appelbaum 1998; Berg et al. 1995; Appelbaum and Grisso 1988; Abernethy 1991). I ascribe the underlying justification for 'respect for persons' in the Indian legal context to recognize that persons have their own values and beliefs and there are certain limitations on the abilities to perceive and know another person's values, beliefs, judgements, and meanings (Darwall 1977, 2006; Buss 1999). Therefore, 'respect for persons' first requires the recognition and acceptance that each individual possesses certain values, beliefs, and meanings, which endow them with the right to be treated as a 'person', and these characteristics lead each person to act in a specific manner within a given context. Moreover, each individual, even a doctor, has certain limitations that they cannot account for, and uncertainties within medicine should be acknowledged (Braddock et al. 1999; Han 2012; Dhawale et al. 2017; Politi et al. 2007). Thus, engaging with patients represents progress towards patient-centred care in every clinical setting, including in the Indian context, where disparities exist between doctors and patients, and attempts should be made to improve the healthcare system at both the micro and macro levels.

Given the rhetoric in the court judgements, I argue that, first, the courts should acknowledge patients as 'persons' who may have different values and preferences with regard to medical treatment than those held by the treating doctors. Treating a patient as a *person* and who is an intersubjective being is a significant reflection of attitudes and actions that demonstrate 'respect for persons'. Drawing on insights regarding this aspect of 'respect' from Darwall (1977) and Buss (1999), I argue that moral attitudes and behaviours that demonstrate respect in institutions can only be achieved when professionals recognize patients and family members as being 'respect-worthy', as *being* 'persons', and constraining behaviours, attitudes, and actions that disrespect or disregard persons. Although the decision-making ‘capacity’ of patients is questioned by the observed rhetoric of the ‘passive patient’, the significance of effective communications and patient-centred care for overall health outcomes is well-acknowledged across health services research and bioethics literature (Ishikawa et al. 2013; Elwyn et al. 2014a; Barry and Edgman-Levitan 2012). The shift from a paternalistic approach to patient-centred care is much-appreciated and welcomed across disciplines (Brazier and Lobjoit 2005; Entwistle et al. 2010; Brazier 1987; Naik et al. 2009; Street et al. 2009; Wasserman and Navin 2018). This change reflects the acknowledgement of patients’ agency and respect for patients’ preferences and choices (Elwyn et al. 2014a; Epstein et al. 2010). In the clinical context, patients should be treated as competent individuals, until they are proven to be otherwise (Abernethy 1991; Grisso and Appelbaum 1998; Faden et al. 1986). However, this study found that patients are presumed to be ‘passive’. ‘Respect for persons’ in the law can be achieved by moving beyond the rhetoric of the ‘passive patient’ and acknowledging the values of patients and their roles during clinical interactions. Furthermore, a significant shift is required within the law, replacing the ‘passive patient’ and the health/choice dichotomy with *patient engagement* and *effective communication* as components of clinical interactions that cultivate the culture of patient-centred care within the healthcare system. Because the purpose of law is to protect vulnerable individuals and to right wrongs, a shift in the narrative that views patients as ‘agents’ who play an active role during clinical interactions would drive both legal and moral progress towards ‘respect’ for both the legal context and society at large.

Conclusion

Over many decades, the concept of autonomy and self-determination has usurped medical paternalism, driving the concept of person-centred care to promote patients as participants during medical decision-making processes. However, as I illustrated in this paper, the rhetorical opinions in the law in the Indian context affirmed the idea of the ‘passive patient’, which must be addressed to acknowledge the role of patients’ values and preferences during decision-making. The constructs of the ‘passive patient’ and ‘doctor knows best’ within the law provide a host of warrants to critically engage on patients’ rights. The rhetoric in the *Samira Kohli* case failed to acknowledge the voices of patients and disregarded their agency and person status by excluding their choices and preferences during medical decision-making processes, based on the notion of protecting their ‘health’. Thus, the rhetoric creates a dichotomy between health/choice for the patient, instead of considering the equal significance that each has on the overall well-being of patients and the decision-making process. The analysis in this paper demonstrates the need for constitutive rhetoric (White 1985), which refers to understanding the ‘rhetoric’ in legal processes, judicial opinions, and rules, and introducing new rhetoric or language into law. Furthermore, this paper illustrated the need to shift the construction of a ‘patient,’ to acknowledge the agentic status of a patient as a person who should be valued during medical decision-making processes and to acknowledge patient engagement and effective communication, to cultivate the culture of patient-centred care in society.

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