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Unnecessary Hysterectomies: Removal of Uterus Scam

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ABSTRACT

We have heard about a lot of scams but probably the most painful and shameful scam of our society which is moreover an irreversible damage is being done to our mothers, sisters and daughters across India over a past few years which is the unnecessary removal of the uterus called Hysterectomy.

The paper seeks to elucidate the unnecessary surgeries being performed by the doctors on thousands of Indian women having their wombs removed in operations that are unnecessary and only performed to make money by unscrupulous private doctors which is a blatant malpractice along with the serious impact on women's mental, physical and hormonal imbalance. The paper also throws light on the issue that why such a procedure has become a regular norm in the villages and how are women made to believe that PERIODS HINDER WORK, attract fines and the work is halted.

The following research paper will also highlight the fact that why are women seen as the most vulnerable part of the society and why is the life of women always at risk, and are there any prevalent laws in the country regarding the same, what parts of country are mostly engaged in the procedure. It also throws light on the fact that there are no records on the number of hysterectomies performed by the private clinic and why are the authorities ignoring the fact that it is an important reproductive health concern. The paper also throws light on the steps taken by the government to resolve the same.

Keywords*: Hysterectomy, scam, blatant malpractice, norm, targeting poor, reproductive health concern.*

I. INTRODUCTION

Doctors in rural India have been carrying out a blatant malpractice by unnecessarily removing the uterus of women called HYSTERECTOMY in an urge to earn money. While accurate statistics on hysterectomies in rural Indian villages are difficult to obtain, local reports and anecdotal data suggest that private doctors scare a number of women into receiving the

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procedure.[2]. Hysterectomy is a disturbing issue in India. The fear of cancer and the reinforcement of their notion that women are advised that unrelated somatic problems are solved by the removal of the uterus.[3].

The surgical removal of the uterus is a hysterectomy, but the above practise is unnecessarily performed on women, most of whom are unaware. Women are being deceived by doctors in private clinics in rural India. The doctors tell these women that a single ultra sound has detected cancer in their uterus, which leads to these women being fooled and removing their uteruses. A hysterectomy cannot be justified by a single ultra-sound and biopsies and other tests are better indicators of cancer or pre-cancer, but doctors pressurise them to do the surgery at the earliest.

In India, there are reports of large numbers of women receiving hysterectomies in some Indian states, and to pay for them, women often have to sell some of their own assets, as these procedures can be costly. Hysterectomies also result from additional health risks inherent in any surgical procedures.

The lack of awareness of Indian women, an exponential shift to the privatisation of healthcare, and a generally patriarchal attitude towards gynaecological problems could be reasons for this disturbing trend to continue.

Women, as well as men, are socialised to believe that the medical community's ethics and expertise ensure competent behaviour on the part of doctors. However, this belief is misguided, the evidence shows that the health care of women is grossly inadequate and in dire need of effective external control and regulation. In the judiciary, the power necessary for such regulation may be established. When faced with claims of medical misconduct, several courses are accessible to the legal practitioner. But because the health field is dominated by profit motivation, the reality of malpractice suits and their accompanying awards can act as an effective means of monitoring physician conduct. While there are many medical abuses inflicted on women, this comment will specifically address unnecessary hysterectomies and the different tort actions available to the patient.

There is a disturbing pattern of performing unindicated hysterectomies with a disregard of ethics in certain pockets of India. The lack of transparency and record keeping of medical records leads to unaccountability. Vaginal discharge-related stigma and fear have a

[2] Women in India Pressurised into unnecessary hysterectomies, WOMEN'S HEALTH RESEARCH INSTITUTE, North western university, http://www.womenshealth.northwestern.edu/blog/women-india-pressured-unnecessary hyster ectomies

[3] Unindicated Hysterectomies in India, Amenda Ann Davis, BMJ Case Reports · December 2019.

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sociological basis and contribute to the misuse of medical treatment.

II. THE EPIDEMIC OF UNNECESSARY HYSTERECTOMY

Hysterectomy constitutes major surgery and carries with it the possibility of death, infection, and other serious post-operative complications[4].

If the ovaries are removed[5], additional complications may arise[6]. Approximately thirty-six percent of all women who have undergone a hysterectomy have been medically treated for postoperative depression[7]. In addition, some research indicates that the physical changes caused by a hysterectomy may affect female sexuality[8]. Despite these complications, hysterectomy is still routinely recommended and performed.

Most hysterectomies are elective-scheduled ahead of time and performed for non-life-threatening purposes. Earlier, hysterectomies were performed only when cancer or a life-threatening situation[9], was present. Today, only 15% of these operations are performed because of gynaecological cancer[10]. Hysterectomies are now performed for everything from backaches to contraception. A commonly used medical argument for hysterectomy is that it will prevent uterine and/or ovarian cancer. However, there is less chance that a woman will die from uterine cancer than from a hysterectomy[11]. Gynaecologists are also using hysterectomy as a form of sterilization instead of the simpler and safer tubal ligation procedure[12]. It appears that gynaecologists are subjecting women to major surgery for dubious reasons at best.

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[4] Hysterectomy complications include: shock; reaction to or infection from a blood transfusion if one is necessary; pulmonary complications; urinary complications such ~s bladder injuries, ureter injuries, diminished urinary output, inability to void, urinary tract infections; venos thrombosis and phlebitis (blood clotting); gastrointestinal complications such as bowel injury, intestinal obstruction or nerve injury.

[5] More than 25% of all hysterectomy patients have their ovaries removed and the % increases to approximately 50% for women between the ages of 35 and 44.

[6] For premenopausal women, the removal of the ovaries will cause the onset of menopause. To prevent menopausal symptoms, physicians routinely prescribe estrogen replacement therapy.

[7] Fifty-five percent of the women operated on for hysterectomies under the age of forty have suffered severe postoperative depression. The researcher defined depression as a condition which when diagnosed by the attending physician was treated with specific anti-depressive drugs. Depression developed in 55% of those who had no abnormality prior to the operation and in 65.5 % of the patients with some preoperative depression, depression developed again. Richards, Depression After Hysterectomy, LANCET Aug. 25, 1973, at 430

[8] The hormonal and anatomical changes associated with a hysterectomy can diminish a woman's sexual response and can even make sexual intercourse painful.

[9] In the 1940's, physicians rarely removed the uterus in the absence of disease. However, the sixties and seventies brought about a change in this practice. Hysterectomies are now being performed for the prevention of uterine cancer, contraception, excessive menstrual bleeding, etc. Contrary to past medical practice, physicians began removing healthy uteri, and elective hysterectomy is now well accepted by the medical community.

[10] A recent study indicates that only 8 to 12 % of the hysterectomies performed are for the treatment of cancer.

[11] The death rate for a hysterectomy is 1,000 out of every 1 million annually compared to 100 out of every 1 million annually for uterine/ cervical cancer.

[12] Hysterectomy is significantly more hazardous than tubal sterilization, yet physicians are still performing hysterectomies for the sole purpose of contraception.

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The sudden increase in the number of hysterectomies performed over the last decade is mainly due to a change in the gynaecological profession's attitudes and practises, rather than any increase in women's diseases.

In the field of gynaecology, the relatively recent medical approval of elective hysterectomy may be partially attributed to profit motivation, teaching hospital needs, and sexism.

Certainly, many women have benefited from properly diagnosed and properly performed hysterectomies. But in the medical community, there is a lot of controversy and uncertainty surrounding determining when a hysterectomy is really necessary.

FINANCIAL MOTIVATION is a determinative factor in the performance of unnecessary hysterectomies. Although most physicians profess to have the best interests of the patient in mind, it appears that financial gain plays an important role in their decision to perform a hysterectomy, at least unconsciously. The surgery is not profitable for prepaid health plans because the doctor is salaried. Hysterectomy rates are therefore much lower than when each operation is paid for by the doctor. Some gynaecologists openly acknowledge this profit motivation[13]. Even more dramatically, hysterectomies are now commonly referred to as "*hip pocket surgery*," where the primary benefit accrues to the physician's wallet.

Some hysterectomies are performed because the residents need the surgical training[14]. Sex stereotyping pervades every aspect of our society, and the medical profession is no exception[15]. The inclusion of sexual stereotypes in medical diagnosis and treatment deleteriously affects the type and quality of women receiving medical care[16]. A physician's decision to perform a hysterectomy is often influenced by sex role stereotyping[17]. The importance of a woman has traditionally been based on her ability to reproduce and raise a family. In line with this role, the importance of her reproductive system in terms of her ability to bear children is still measured by many gynaecologists. The uterus becomes non-functional and medically dispensable once childbearing is completed**.**[18]. Moreover, male doctors are more willing to

[13] Guralnick, Women are Learning of Their Rights as Patients and Malpractice Victims, Pa. L.J., Nov. 10, 1980, at 6; a gynecologist recently stated that, "[slome of us aren't making a living, so out comes a uterus or two each month to pay the rent."

[14] Some residency programs also require residents to perform a certain number of surgical procedures before speciality status will be granted.

[15] B. EHRENREICH & D. ENGLISH, COMPLAINTS AND DISORDERS: THE SEXUAL POLITICS OF SICKNESS (1973).

[16] Sexism in medicine also affects the amount of information physicians are willing to give their patients. Women are often considered too stupid and emotional to comprehend and cope with vital information concerning their illnesses.

[17] Gynaecologists frequently remove healthy organs and advise women to have hysterectomies under the guise of preventing uterine cancer.

[18] The uterus has been referred to by the medical community as a "useless, bleeding. . . potentially cancer-bearing organ .... "

operate on the bodies of women than on those of their own sex.[19]. The casual way in which female organs are removed by gynaecologists may be attributed to their inability to empathise with the emotional and physiological impacts of such surgery.

III. FACTORS THAT LEAD TO HYSTERECTOMY

When women don't understand the procedures, they can't ask the right questions. If they can't ask the right questions, they can't give true consent to a procedure. Nearly 100 percent of women believed in a study conducted by SEWA and London School of Hygiene and Tropical Medicine in Gujarat that removal of the uterus would solve their health problem and that the organ is of no use other than during pregnancy. Other studies have shown that many women also believe the operation **would take away period pain and will increase the days of productive work.** These misconceptions show us another important challenge: most of these women do not have a fundamental understanding of how their body functions and the important role of reproductive organs. Such rural illiterate women can only be part of an informed and informed consent-based treatment process if we focus on educating women and girls about their sexual and reproductive health and rights. Indications of hysterectomy, such as vaginal discharge, enlarged uterus or unspecific fibroids, and symptomatology, are often vague. Lack of social and financial security, lack of knowledge of reproduction as the sole function of the uterus and ovaries, and lack of access to primary healthcare are the factors leading to hysterectomy.

These women are very easily convinced that hysterectomy, particularly if they do not use any form of contraception, is a permanent solution. This social situation and 'consumer demand' encourage healthcare providers to provide hysterectomy for not only gynaecological problems, but as a portrayed panacea for all women's health problems, often as a first-line treatment.

Studies have found a significant correlation between sexual abuse before the age of 15 and chronic pelvic pain later on[20] [21].

In India and presumable mostly in the cases of Child Marriage the girl does not reports abuse which she suffers from the male family members before marriage and even from her husband after marriage. A survey in Northern India estimated the prevalence of physical and sexual abuse of women, with a strong association with sexually transmitted infections and unwanted

[19] Women's reproductive systems are operated on far more often than are male reproductive systems.
[20] Lampe A, Sölder E, Ennemoser A, et al. Chronic pelvic pain and previous sexual abuse. Obstet Gynecol 2000;96:929–33.
[21] Paras ML, Murad MH, Chen LP, et al. Sexual abuse and lifetime diagnosis of somatic disorders: a systematic review and meta-analysis. JAMA 2009;302:550–61.

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pregnancies, at an appalling 46 %.[22] In addition to the inherent social problems, integrated services for gynaecologists, urologists, surgeons and psychosocial counsellors are often lacking, even in tertiary care centres, which are essential for helping such women. The majority of such women are misled to feel that surgery (hysterectomy) is the best, only or most permanent solution in the absence of sensitive counselling and a varied approach.

There are very few studies that highlight the role of gender in medicine in India, and from the limited facts, one can only assume the reality. There is a very dismal proportion of women who are part of the medical task force. WHO estimates put the country-wide ratio of male: female doctors at 5:1[23].

Consumers do not have any input in health care policy making or in the monitoring of physician performance. The medical profession is relatively free from outside regulation and the few regulatory bodies that do exist are usually physician dominated and essentially ineffective[24]. The education of newcomers and the quality of medical care is exclusively controlled by the medical community[25]. As a result, physicians are usually the only ones in a position to monitor their colleagues' performance. Evidence suggests, however that the medical profession does not regulate itself adequately. In the health care field, this lack of effective medical regulation gives doctors unbridled reign. The rise in claims of medical malpractice indicates that the medical community has made some serious abuses and mistakes, the effects of which are mainly felt by women. Doctors have repeatedly subjected women to unnecessary surgery.[26] Sexual prejudices harboured by most male physicians, coupled with women's ignorance concerning their own bodies[27], make women particularly vulnerable to medical abuse.

When faced with claims of medical misconduct, several courses are available to the legal practitioner[28]. But due to the fact that profit motivation dominates the health field, the reality of malpractice suits and their accompanying awards may act as an effective means to monitor physician behavior[29].

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[22] 3 Martin SL, Kilgallen B, Tsui AO, et al. Sexual behaviors and reproductive health outcomes: associations with wife abuse in India. JAMA 1999;282:1967–72.
[23] Fan V, Anand S. The health workforce in India 2016.
[24] M. MILLMAN, THE UNKINDEST CUT: LIFE IN THE BACKROOMS OF MEDICINE (1977).
[25] SCULLY, supra note 2, at 12-13.
[26] Larned, The Epidemic in Unnecessary Hysterectomy, in SEIZING OUR BODIES 195 .
[27] Women are conditioned at an early age to be embarrassed by and ashamed of their own bodies. Society also teaches women that female sexuality is unimportant and even non existent. Such indoctrination further perpetuates the already existing ignorance surrounding women's health matters by making women reluctant to ask their physicians questions concerning their own bodies.
[28]Citizen Petitioning of Federal Administrative Agencies-Domestic Infant Formula Misuse: A Case Study, 12 GOLDEN GATE U.L. REV. 606 (1982).
[29] S. MORGAN, COPING WITH A HYSTERECTOMY 52 (1982)

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IV. SITUATION PREVAILING IN INDIA

This case of women being pushed into unnecessary hysterectomy is not uncommon in India. While education and awareness have led to a declining preference for hysterectomy in the west[30], the same cannot be said of India, where women still consider the uterus as a dispensable burden. It highlights the severe complications of unnecessary hysterectomies, as well as healthcare system problems and inequities that plague Indian society. India is one of 81 countries that contribute significantly to 95% of the world's maternal deaths, and achieving the sustainable goal of health for all by 2030 seems to be a daunting task.[31]

Situation in India is considered to be worse due to the fact that contractors force the female workers to get hysterectomies done so that they do not take leaves, as they believe that PERIODS HINDER THEIR WORK. Women have also accepted the fact and get it done taking large amount of loans. It has moreover become a norm in the villages that after having 2 children one should get it done, as it would also save them a lot of money because they will not have to buy pads and will lead to less burden on them financially.

Data from the national family and health survey puts India's hysterectomy rate at 3.2 percent, with significant differences between different states. The rate in Bihar, for instance, was 5.4%, and Andhra Pradesh had a maximum rate of 8.9%. Almost 70% of these were carried out in the private sector, with significantly higher rates among the less educated and rural populations. Localized audit-based studies, in contrast, report alarmingly higher rates. A study aimed at tracing the focal points of such activity in the state of Karnataka found that almost 50 percent of women who had undergone hysterectomy were under 35 years of age, mostly from low-income families, and were coerced into surgery at exorbitant rates of cancer risk. Before the operation, many of these women were not even examined, without an operative note or histopathological examination.[32].

In Gujarat, the estimated rate of hysterectomy is 20.7 per 1000 women years, almost four times higher than countries such as the United States, Germany and Australia [33]. This compares to the study which found that the rate in Andhra Pradesh was 17 per 1000 women, with more than

[30] Wright JD, Herzog TJ, Tsui J, et al. Nationwide trends in the performance of inpatient hysterectomy in the United States. Obstetrics & Gynaecology 2013;122:233–41.
[31] Countdown to 2030 Collaboration. Countdown to 2030: tracking progress towards universal coverage for reproductive, maternal, new born, and child health. The Lancet 2018.
[32] Xavier T, Vasan A, S V, et al. Instilling fear makes good business sense: unwarranted hysterectomies in Karnataka. Indian J Med Ethics 2017;2:49–55.
[33] Desai S, Campbell OMR, Sinha T, et al. Incidence and determinants of hysterectomy in a low-income setting in Gujarat, India. Health Policy Plan 2017;32:68–78

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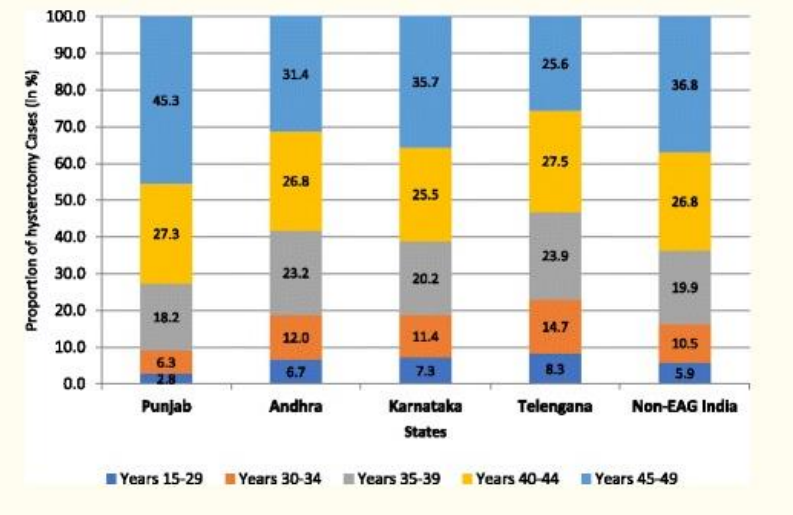
one-third of women undergoing hysterectomy under the age of 40 years[34]. A right to information request in Rajasthan revealed that 286 out of 385 operations reported by three private hospitals were hysterectomies, many of which were performed in women under 30 years of age, with the youngest being 18 years of age.[35] Although many of these are paid for by out-of-pocket spending, it has been observed that practitioners also misuse government insurance schemes.

The average prevalence rate of hysterectomy was estimated to be 17/1000 among ever married women in the ages of 15–49 years. As many as 5567 women out of the total 3, 16, 361 reported having undergone hysterectomy. There were wide variations in the prevalence rates across the different states and union territories in India, ranging from 2/1000 to 63/1000 women. Among the large Indian states, the lowest prevalence rates of hysterectomy were reported in the states of Tamil Nadu and Haryana – nearly 6/1000 women in both states. On the other hand, the state of Andhra Pradesh had the highest prevalence rate of hysterectomy (63/1000 women), followed by Telangana (55/1000), Karnataka (29/1000) and Punjab (23/1000).

The current median age of the women undergone hysterectomy was 42 years in all the states covered in the survey. It is important to note that many women reported undergoing the surgeries at younger ages: more than one-third (36%) of all the women who got their hysterectomy done did so before reaching 40 years of age. Furthermore, the high hysterectomy prevalence states of Andhra Pradesh and Telangana had a much higher proportion of women under 40 years of age who had hysterectomy, 42% and 47% respectively[36].



[34] Prusty RK, Choithani C, Gupta SD. Predictors of hysterectomy among married women 15–49 years in India. Reproductive health 2018;1:3.

[35] Prayas Trust. Understanding the reasons for the rising numbers of hysterectomies in India. National consultation, 2013. Available: http://www.prayaschittor.org/pdf/ Hysterectomy-report.pdf

[36] Proportion of women who underwent hysterectomy by the age of women in selected Indian states, 2012–13

In particular the states of Andhra Pradesh and Telangana (which were one state until recently) appear to be the hotspots of hysterectomy. Indeed, these states have been the focus of debate on unnecessary and forced hysterectomies in India, particularly involving young, pre-menopausal women from the poor socio-economic backgrounds.

These cases are not only a gross violation of sexual and reproductive health rights, but they have also exploited the labour laws in many instances. Many women have been forced to have hysterectomies so that they can be employed as cane cutters without having time to interrupt their ability to operate.

V. A PHYSICIAN'S LIABILITY FOR UNNECESSARY HYSTERECTOMIES

Practitioners in the medical malpractice field are handling more and more cases involving women's health issues. Malpractice attorneys attribute this rise to women's increasing awareness of their own health and physiology. More women complain that in connection with this awareness, they received unnecessary surgery. Unnecessary operations are often alleged to be hysterectomy, mastectomy and Caesarean section, and hysterectomy is probably the most abused of all major surgical procedures.

The theories which can be used to state a cause of action for unnecessary hysterectomy are negligence, battery, and informed consent. To assess whether these theories are actionable in a given situation, the practitioner must consider the various elements involved in each theory and the attendant proof problems. Of the three, informed consent is the most viable.

(A) Informed Consent

It is well established that a physician must obtain the patient's consent before performing an operation or treatment[37]. A cause of action for lack of informed consent may be brought under two legal theories: battery and/or negligence. Lack of informed consent constitutes ASSAULT under section 351 of the Indian Penal Code.

An action for battery is appropriate when a physician:

(1) operates without consent

(2) Performs a procedure that is substantially different from the consent given

(3) fails to disclose a risk which has a substantial certainty of occurring or

(4) exceeds the scope of the consent granted[38].

[37] Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125.
[38] Hundley v. St. Francis Hosp., 161 Cal.

Women should be taught about their right to seek health information, including a second opinion in cases of invasive surgery. Ultimately, they should be made aware that they have full control over their body and they should only consent to medical decisions after having all the information.

1. Battery

The plaintiff only needs to establish that intentional, harmful or offensive touching occurred without consent in order to maintain a cause of action for battery. Any treatment without the patient's consent by a physician constitutes battery. Although the surgery or medical treatment has been skilfully performed, the battery can lie. If battery is proven, for all injuries arising from that touching, and if appropriate, punitive damages, the patient may recover damages for the wrongful touching. Section 350 of the Indian Penal Code deals with the same.

The physician has a very limited disclosure obligation under the battery theory where he only needs to inform the patient of the nature of the medical procedure, of what he intends to do to the patient. The doctor has the additional obligation to "properly explain to his patient a contemplated procedure or operation in a way that the patient can reasonably understand in order for the patient to give his informed or knowledgeable consent."[39]. Therefore, in a reasonably understandable way, the doctor must at least inform the patient that a hysterectomy involves the removal of the uterus and will cause sterility.

In most situations, the patient is advised as to the nature of the medical procedure and consent has generally been given. This consent "carries with it a consent to remove an organ or body tissue which is a normal incident to the operation," but when the surgery goes beyond the scope of the patient's consent, an action for battery will lie. However, if abnormal conditions are found during the course of the operation, an operation may be surgically extended by a surgeon and immediate action is necessary to preserve the life or health of the patient and it is impractical to obtain consent for an operation that he considers immediately necessary[40]."

This informed consent exception generally occurs with regard to hysterectomy when a woman has consented to a hysterectomy or laparotomy and the surgeon has extended the surgery beyond the consent of the patient.[41]. Responsibility for such excess surgery will depend on whether this extension has been medically warranted. The choice is in the doctors' hands once

[39] Robertson, Informed Consent to Medical Treatment, 97 L.Q. REV. 102, 111-12 (1981)
[40] Hundley v. St. Francis Hosp., 161 Cal. App. 2d at 806-07, where (the surgeon exceeded the scope of the patient's consent by removing her uterus, fallopian tube and remaining ovary).
[41] If a patient has consented to a hysterectomy, the surgery often ends with the excision of the woman's ovaries as well. The practitioner should be aware that medical justification for extending the scope of surgery will defeat a battery claim. Wheeler v. Barker, 92 Cal. App. 2d at 781, 208 P.2d at 71

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again. Because the medical justification for the removal of a woman's reproductive organs is easily met, it is unlikely that a battery claim will successfully limit the scope of surgery in this area. While doctors usually advise their patients on the nature of the medical procedure involved, when eliminating a hysterectomy incident of female ovaries, it is questionable whether gynaecologists fulfil their disclosure duty.

Many surgeons automatically remove the ovaries during a hysterectomy, whether they are diseased or not.[42]

If a physician follows this accepted medical practice, he must disclose this to the patient. In BANG V. CHARLES T. MILLER HOSP[43], the patient consented to prostate gland surgery and his spermatic cords were severed by the surgeon. The patient claimed that the failure of the surgeon to obtain his consent regarding the severance of his cords constituted battery[44]. The court held that the patient should have been informed by the surgeon that the procedure involved the severing of his spermatic cords. Similarly, if as part of his standard surgical procedure for hysterectomy, a gynaecologist automatically removes the ovaries, he must disclose this to the patient in order to avoid battery liability.

The law of consent in battery affords the patient little protection because most physicians believe that the patient should know the nature of the proposed medical treatment. However, significant disclosure by the medical community is not standard practice especially with respect to its female patients. Usually, the information necessary for the patient to make an informed choice concerning the treatment is withheld or unavailable.

Many allegations of lack of informed consent are framed by negligence. This cause of action is appropriate when the physician performs the approved treatment, but does not disclose possible complications or alternative treatment methods before obtaining the consent of the patient. However, the practitioner should be conscious of the legal implications of bringing a cause of action for lack of informed consent based on a theory of negligence as opposed to battery.[45]

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[42] Gynaecologists automatically remove these organs at varying cut off ages, some as low as age 40. The medical rationale for this is the 'prevention of ovarian cancer. However ovarian cancer is very rare and accounts for only one percent of all cancer cases.

[43] Cobbs v. Grant, 8 Cal. 3d at 239

[44] Bang v. Charles T. Miller Hosp., 251 Minn. at 428

[45] Framing a cause of action in battery as opposed to negligence can have important ramifications: (1) the statutes of limitations can differ; (2) some malpractice insurance policies exclude intentional torts from coverage; (3) suits against government physicians and hospitals can be affected (the Federal Tort Claims Act excludes intentional torts); (4) expert testimony is not required for a battery claim; the plaintiff need only prove that an intentional harmful or offensive touching absent consent occurred; and, (5) punitive damages are available only under a battery theory.

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2. Negligence

To establish a cause of action for lack of informed consent based on negligence, the plaintiff must demonstrate:

(1) A breach of the physicians' duty to disclose all known information material to the patient's decision to undergo a particular operation or medical procedure;

(2) that plaintiff was injured as a result of the undisclosed information; and

(3) that the plaintiff would not have submitted to the operation or treatment if she had known of the undisclosed information.

Even if the medical treatment or surgery is performed within the medical standard of due care, if he fails to inform the patient of relevant medical information, a physician may still be held responsible for medical malpractice.

Under a negligence theory, the physician must disclose:

(1) the inherent risks of the medical procedure;

(2) medical alternatives to the proposed treatment;

(3) the probability of a successful outcome; and

(4) the medical consequences if the patient remains untreated[46]. The scope of this disclosure has traditionally been set by the medical community and is determined by what is sound medical practice under the circumstances[47]. Section 304A of the Indian Penal Code deals with the same.

While doctors usually advise their patients on the nature of the medical procedure involved, when eliminating a hysterectomy incident of female ovaries, it is questionable whether gynaecologists fulfil their disclosure duty.

If the trier of reality concludes that the data is what material the reasonable person in the position of the patient would consider, and the doctor failed to disclose this information, the doctor has breached his obligation of disclosure.

Liability for unnecessary surgery arises from the negligence involved in the decision of the physician to operate rather than the way in which the operation is performed. The law requires doctors to exercise "that reasonable degree of skill, knowledge and care ordinarily possessed and exercised by doctors under similar circumstances in diagnosis and treatment, with no

[46] Truman v. Thomas, 27 Cal. 3d 285, 292, 611

[47] The term "professional standard" refers to utilizing prevailing medical standards to determine the physician's duty of disclosure.

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different or higher degree of responsibility than that in their professional community." Treatment that is prohibited by customary medical standards or fails to do something that those standards require in reaching their decision to operate[48]. Expert testimony must establish the standard of due care of the medical community and the deviation of the doctor from it. The patient has the additional burden of proving that once this deviation has been established, the negligence of the doctor caused the patient's injury.

If a physician chooses to operate without previously administering tests that would have been performed or misinterpreted by a reasonable physician, negligence will be found[49].

In DAVIS V. ZERWICK**[50],** negligence was found when the physician failed to perform adequate diagnostic tests on the patient before performing the surgery. The doctor was held responsible for performing an unnecessary hysterectomy and recovering the damage. Therefore, if a patient alleges unnecessary surgery for failure to perform the correct diagnostic tests, the patient must demonstrate what tests, under similar circumstances, would have been used by a reasonable surgeon, the doctor's failure to perform such tests, and that a reasonable surgeon would not have performed based on what the tests would have shown.

Negligence can also be established if a surgeon continues to cut beyond the point where reasonable surgeons stop[51]. In HUNDLEY V. ST. FRANCIS HOSPITAL, the surgeon, during authorized surgery, performed a hysterectomy and excised the patient's last remaining ovary and fallopian tube. No sign of abnormality was shown in the pathological examination of the removed organs. The patient's medical experts testified at trial that it was not medically justifiable to remove healthy organs. The physician offered testimony that certain results revealed that organ removal was warranted during the course of the authorised surgery. The jury rejected this argument and found the surgeon negligent for having performed unnecessary surgery. Therefore, if the surgeon exceeds what is medically warranted to cure the patient's illness, an operation that is initially required may become actionable for negligence. The doctor will be responsible for the pain and suffering caused by unnecessary surgery and any associated complications whenever the preoperative diagnosis is found to be negligent[52]. However, under

[48] In **Copeland v. Robertson, 256 Miss. 95,** the patient was diagnosed as having an ovarian cyst with an acute pelvic infection. In an attempt to alleviate these problems, the physician performed a hysterectomy. Medical experts at trial testified that the operation should not have been performed while the infection was acute and that the infection should have first been treated by antibiotics. In addition, expert testimony indicated that the surgery may well have been unnecessary because the drugs might have cured the infection. The jury found the physician negligent for performing the hysterectomy.

[49] Lundberg v. Bay View Hosp., 191 N.E.2d 821.

[50] Davis v. Zerwick, 24 JURY VERDICTS WEEKLY No.9, at 15 (1980).

[51] Copeland v. Robertson, 112 So. 2d at 240 (treatment of infected tubes and ovaries did not medically warrant the removal of the uterus.).

[52] Approximately 30 to 40% of all hysterectomies will result in complications ranging from permanent damage of

a negligence theory, many hysterectomies are not actionable because the decision of the physician to operate usually does not violate the medical community's standards.

VI. DISCLOSURE OF HYSTERECTOMY RISKS

Many cases of informed consent have stemmed from the failure of the doctor to disclose the inherent risks associated with the medical procedure. In part, the reason for this may be attributed to the adherence of the medical profession to societal sex roles. Gynaecologists often treat women as if they were children and think that the dissemination of too much data will cause the female patient to be unnecessarily anxious. The willingness of gynaecologists to give women the information necessary to make informed decisions is adversely affected by these attitudes. Despite the reluctance of doctors to disclose information, before consent is given, women have a legal right to know the material hazards of the proposed medical treatment.

The physician must inform the patient of the associated risks when surgery or other hazardous therapeutic procedures are being considered. "the potential of death or serious harm, and to explain in lay terms the complications that might possibly occur." The potential for death or serious harm and to explain the complications that may occur in lay terms. For hysterectomy, the operative death rate is between 0.3 and 0.5 % and the doctor must disclose this risk to the patient. The disclosure of other risks associated with hysterectomy to the patient's decision will depends on their materiality.

Although the courts have not established a specific probability figure for triggering the duty of the doctor to inform, the duty appears to usually increase as the severity and incidence of the injury increases.[53]

The obligation of disclosure relates only to those risks that are actually inherent to the medical procedure. Expert testimony must establish the existence and rate of incidence of such risks. Although the hysterectomy complication rate is over thirty percent,[54] women rarely sue their doctors for failing to tell them about the potential risks associated with hysterectomy.

Although the courts generally refuse to impose a duty on doctors to disclose this risk, when weighing the severity and incidence rate of this injury, the practitioner should not immediately discount its legal significance.

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the urinary tract to sexual dysfunction.

[53] Generally, if the risk is statistically high, the patient should be informed of such. If the risk is statistically low and extremely severe, the patient should again be informed; but if the statistical risk is minimal and not serious, the physician will probably not be required to disclose this risk.

[54] Dicker, Complications of Abdominal and Vaginal Hysterectomy Among Women of Reproductive Age in the United States, 144 AM. J. OBSTETRICS & GYNECOLOGY, 841 (1982).

Statistically, the morbidity rate from hysterectomy is high. Postoperative fever, infection, urinary tract injury, depression, and sexual dysfunction are among the known risks. Again, determining whether these hazards should be disclosed depends on their materiality in the decision of the patient. The more permanent injuries, such as sexual dysfunction and certain injuries to the urinary tract, will, however have a greater impact on the life of the patient and will directly affect the severity variable in the materiality test.[55]

(A) Disclosure of Alternative Treatments

When considering surgery, the physician must inform the patient of the alternatives available and the risks involved, so that the patient can make an informed medical treatment decision.

"As an integral part of the overall obligation of the physician to the patient, there is a duty to reasonably disclose the available choices with regard to the proposed therapy and the dangers inherently and potentially involved in each one." The disclosure of medical alternatives with respect to a hysterectomy will depend on the woman's diagnosis.

Approximately 15 % of all hysterectomies are clearly questionable and treatable by less drastic means. Most of the remaining hysterectomies, although medically substantiated, can be treated by other acceptable methods. These alternatives must be disclosed, although rarely disclosed by doctors, so that women can make fully informed choices regarding the health and integrity of their own bodies.

The most frequent diagnosis leading to hysterectomy is uterine leiomyoma or fibroids[56]. Fibroids have a 0.5% chance of becoming malignant and usually decrease in size with the onset of menopause. However, the presence of fibroids is used by gynaecologists to persuade women to have hysterectomies. Physicians' use of the term "tumour" to describe fibroids is often used to elicit the fear of cancer and therefore prompt women into having the operation.

It is estimated that approximately 16 % of all hysterectomies are performed for the purpose of sterilization. In addition, a number of physicians contend that some hysterectomies are actually performed for sterilization purposes, but that the physician has indicated otherwise on hospital records so that insurance companies will cover the operation. For sterilization, tubal ligation is the recognized alternative to hysterectomy[57].

Many symptoms treatable by hysterectomy can be treated by less drastic means and courts are

[55] Any impairment of female sexuality by a hysterectomy must be considered as a serious injury in the weighing process associated with the materiality test.
[56] Fibroids are benign tumours that grow in the muscle tissue of the uterus. One out of every four women will develop fibroids. L. LANSON, FROM WOMEN TO WOMEN (1978).
[57] Tubal ligation is well accepted by the medical community and is recognized as safer than hysterectomy.

willing to impose a duty on physicians to disclose these medical alternatives so that women can make informed decisions concerning whether to undergo this kind of major surgery. However, once the duty is established, the requisite elements of causation must be shown before recovery will be allowed.

There must be a causal relationship between the failure of the physician to inform and the patient's resulting injury. The plaintiff must demonstrate:

(1) that the plaintiff was injured as a result of the undisclosed information; and

(2) that "but for" the failure to disclose, she would not have submitted to the operation. The patient must prove both causal elements in order to recover.

The first element requires that the undisclosed risk actually materialise and that the patient be injured as a result of undergoing the medical procedure. "The very risk which the duty of disclosure of a physician is designed to cover is to prevent the performance of operations which the patient would not consent to if fully informed." The requirement that the risk materialise is met by the very fact that, without being fully informed of the alternatives, the patient underwent the surgery. Unnecessary removal of their reproductive organs is the harm suffered by women who undergo hysterectomies without knowledge of the alternatives. On the basis of the failure of the doctor to disclose alternative treatments, this element appears to pose little difficulty for the patient claiming lack of informed consent.

The second element of causation requires the application of the following test- would a reasonable person in the patient's position decline the proposed treatment if she had been fully informed of the medical alternatives. Applying this test to hysterectomies, the trier of fact must weigh the risks associated with a hysterectomy against the risks of the alternate treatment.

The court in STEELE VS. ST. PAUL FIRE & MARINE INS. CO,[58] performed such a balancing test. The basis of the patient's claim was that because the surgeon did not disclose a medically approved alternative, she failed to give her informed consent to a hysterectomy. The court found the necessary causal link between the physician's failure to disclose and the patient's injury by weighing the risks associated with the hysterectomy against the risks of alternative treatment. In finding this connection, the court noted that the patient was 28 years of age and wanted to have more kids. The court gave great weight to the loss of its ability to have children because the loss was medically certain, while the risks associated with the surgery were not so great. The court concluded that, had she been informed, the patient would

[58] 371 So.2d at 843.

have accepted the risks inherent in the alternative treatment and declined the hysterectomy. Thus, the courts recognise the severity of the damage associated with the elimination of the reproductive potential of a woman without her informed consent. Even if the complainant is not in childbearing years, however the pain and suffering associated with an unnecessary hysterectomy and the potential for complications will weigh in finding the cause that is necessary.

Courts appear to be more willing to impose a duty on doctors to reveal these alternatives than to require them to reveal the risks of a hysterectomy.

VII. DAMAGES

"Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent is liable for damages." However, with respect to unnecessary hysterectomy, the economic and sexist realities of our society have abrogated this right of individual choice for many older women[59].

With claims of unnecessary hysterectomy and allegations of lack of informed consent, a woman who is still in her childbearing years has a greater chance of collecting heavy damages than does an older woman. The jury in California awarded $1,500,000 to a 25-year-old woman who had her reproductive organs removed without her consent[60].

Because of the sex roles of our society, the importance of a woman is often interwoven with her ability to have and raise a family. Consequently, the large awards associated with the unnecessary termination of a female's ability to procreate are not surprising.

However, as women age beyond their childbearing years due to limited recovery of harm, legal practitioners are not as willing to accept unnecessary hysterectomy or lack of informed consent claims. Perhaps this lack of willingness can be attributed to the same assumptions that the surgeon who performed the hysterectomy made about the sexual role of a woman. If the uterus of a woman is thought of after years of childbearing as a useless organ, then there is probably little harm caused by its unnecessary removal. As a consequence of this view, lawyers do not represent women with these types of claims and juries, who have the same social values, do not award large settlements. However, as a younger woman, an older woman who has undergone an unnecessary hysterectomy or who has not consented to the procedure has

[59] Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125

[60] Such a large award can be attributed, in part, to the evidence and testimony at trial which indicated that the plaintiff really wanted to have children. Thimatariga v. Chambers, 416 A.2d 1326 (Md. App. 1980).

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suffered a serious violation of her bodily integrity and is equally entitled to mere compensation.

In the case of SAMIRA KOHLI VS PRABHA MANCHANDA AND ORS. the applicant was admitted only for a diagnostic procedure, namely a laparoscopy test, and as she had given consent only for a laparoscopy test and as her mother's consent for conducting hysterectomy had been obtained by misrepresentation, there was no valid consent for the radical surgery. The respondent also tried to cover up her unwarranted/negligent act by falsely alleging that the appellant was suffering from endometriosis. The respondent was guilty of two distinct acts of negligence: the first was the failure to take her consent, much less an informed consent, for the radical surgery involving removal of reproductive organs; and the **second** was the failure to exhaust conservative treatment before resorting to radical surgery, particularly when such drastic irreversible surgical procedure was not warranted in her case. The respondent did not inform the appellant, of the possible risks, side effects and complications associated with such surgery, before undertaking the surgical procedure. Such surgery without her consent was also in violation of medical Rules and ethics. Removal of her reproductive organs also resulted in a severe physical impairment, and necessitated prolonged further treatment. The respondent was also not qualified to claim to be a specialist in Obstetrics and Gynaecology and therefore could not have performed the surgery which only a qualified Gynaecologist could perform[61].

IN CANTERBURY V. SPENCE 1972 [464] FEDERAL REPORTER 2D. 772**,** the United States Courts of appeals, District of Columbia Circuit, emphasized the element of Doctor's duty in 'informed consent' thus:

It is well established that the physician must seek and obtain the consent of the patient prior to the commencement of surgery or other treatment. It is also clear that in order to be effective, the consent must be free from the imposition on the patient. It is a settled rule that therapy not authorised by the patient may amount to a tort- battery, and it is evident that it is normally impossible to obtain a consent worthy of the name unless the physician first elucidates the options and risks for building up the patient. Thus, on pain of liability for unauthorised treatment, the physician has long been obliged to make adequate disclosure to the patient.

The basic principle in regard to patient's consent may be traced to the following classic statement by Justice Cardozo IN SCHOENDORFF V. SOCIETY OF NEW YORK HOSPITAL (1914) 211 NY 125:

Every human being of adult years and sound mind[62] has a right to determine what should be

[61] Samira Kohli vs. Prabha Manchanda and Ors. (16.01.2008 - SC) : MANU/SC/0430/2008

[62] Sound mind, the words sound mind does not mean that the testator should have mental faculties in their fullest

done with his body and a surgeon who performs the operation without his patient's consent, commits an assault for which he is liable in damages. This principle has been accepted by English court also, the House of Lords while dealing with a case of sterilization[63] of a mental patient reiterated the fundamental principle that every person's body is inviolate and performance of a medical operation on a person without his or her consent is unlawful.

Any intentional touching of a person is unlawful and amounts to the tort of battery unless it is justified by consent or other lawful authority. In medical law, this means that a doctor may only carry out a medical treatment or procedure which involves contact with a patient if there exists a valid consent by the patient (or another person authorized by law to consent on his behalf) or if the touching is permitted notwithstanding the absence of consent[64].

In MURRAY V. MC MURCHY 1949 (2) DLR 442, THE SUPREME COURT OF BC, CANADA**,** was considering a claim for battery by a patient who underwent a caesarean section. During the course of the caesarean section, the doctor found fibroid tumours in the uterus of the patient. In view of the fact that such tumours would be a danger in the event of future pregnancy, he performed a sterilisation operation. The court upheld the battery claim for damages. It held that sterilisation could not be justified on the basis of the principle of necessity, since there was no immediate threat or danger to the health or life of the patient, and it would not have been unreasonable to postpone the operation in order to obtain the consent of the patient. The fact that the doctor found it convenient to perform a sterilisation operation without consent, as the patient was already under general anaesthetic, did not appear to be a valid defence.

VIII. STEPS TAKEN

Organizations are currently working to make changes that will improve the health of women in rural India. As health clinics are necessary and helpful, campaigners are focusing on improving the supervision and regulation of physicians working in these clinics to ensure that women are not fooled or frightened by unnecessary procedures. Legislations to regulate private health care has been passed in India, but it is still in the process of implementation and is not yet effective. For the time being, it is important to raise awareness about this issue and to continue working to improve women's health everywhere.

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vigour, but he should have capacity to understand the nature of his property and a judgment of his own in making the dispositions, Rayali Kameshwar v. Bendopudi, AIR 1962 AP 178 (184). (Succession Act, 1925, s. 59)- Samira Kohli vs. Prabha Manchanda and Ors. (16.01.2008 - SC) : MANU/SC/0430/2008

[63] In Re : F. 1989(2) All ER 545,

[64] The English law on this aspect is summarised thus in Principles of Medical Law (published by Oxford University Press -- Second Edition, edited by Andrew Grubb, Para 3.04, Page 133):

The Indian Medical Association shall take action against non-ethical health care providers. However there have been instances where a doctor has had a licence cancelled in one state, only to re-establish a practise in another state, due to varying laws and lack of a unified licencing review. A new bill called the NATIONAL MEDICAL COUNCIL BILL is underway, which aims to eliminate corruption in the current medical institution by having a government elected council. It also aims to create more doctors by creating a 'bridge course' which will train nurses and paramedics for a specified period of time so that they can prescribe medicines. Such proposals have been met with a great deal of scepticism by the medical task force, but it is clear that some radical change is needed in the system.

A few steps have been taken in the right direction. Both the state and central governments of India have recognised cases of unscrupulous hysterectomy as major medical malpractice following campaigns by various public health organisations and medical authorities. This led to the inclusion of hysterectomy data in the 4TH NATIONAL FAMILY HEALTH SURVEY (NFHS-4). The Indian Medical Research Council is currently drawing up stricter guidelines for the use of hysterectomy. The FEDERATION OF OBSTETRIC AND GYNAECOLOGICAL SOCIETIES OF INDIA has also launched a campaign called 'Save the uterus,' which promotes the use of non-invasive procedures to treat gynaecological problems and makes the removal of the uterus the last resort and has trained physicians in these alternative procedures.

The Indian Government is in the midst of designing and implementing a new national policy for women. The DRAFT NATIONAL POLICY FOR WOMEN (NPW) 2016 focuses on, among other things, improving women's health through a holistic and life-cycle approach that includes provision of appropriate, affordable and quality health care services. In addition, this draught policy also explicitly recognises the lack of health care services for older, menopausal women. While government health insurance schemes are designed to protect poor and vulnerable populations from catastrophic health costs, evidence that they could also lead to unnecessary hysterectomy warrants a need for better design of health protection plans. Finally, there is a need for national health statistics and surveys, such as the National Family Health Survey, to provide information on hysterectomy.

IX. CONCLUSION

Every year, 800,000 women undergo hysterectomies According to the most conservative estimates, approximately 120,000 of these will be unnecessary[65]. Despite the spread of this

[65] According to a recent estimate, approximately 15% of all hysterectomies performed are unnecessary.

unnecessary surgery, most women are unaware of the medical abuses associated with hysterectomy. This ignorance, coupled with the reluctance of the medical profession to provide relevant medical information that would allow women to evaluate their doctor's performance properly, makes it very difficult for women to recognise medical malpractice. In general, a legal remedy will not be pursued even if a woman is aware that her surgery may have been unnecessary. Therefore, most of the actionable malpractice claims are either undetected or never pursued for unnecessary hysterectomy.

A lack of malpractice claims for unnecessary hysterectomy can also be attributed to the present state of malpractice law. The deference to the judgement of the medical community is enshrined in the law. Ordinary negligence and the majority view of informed consent law determine negligence by measuring the performance of the physician against the standards of the medical community. In its current state, the law will discover and eliminate individual behaviours that deviate from the medical norm, but it will not deter misconduct that is universally followed by the profession. The prevention of unnecessary hysterectomy must therefore be achieved by other legal means.

Evidence on the health after-effects of hysterectomy is mixed, research shows that hysterectomy at an early age has severe ill-effects on women's physical, mental and social wellbeing including incontinence[66] sexual dysfunction[67] and earlier onset of menopause with increased risks of cardiovascular diseases. Women have been shamed and suffered for a long time because of the culture of silence surrounding their bodies. In this war against women's health, bodies, and rights, women at the bottom of the pyramid are the worst affected. It is high time that women have the tools to make informed decisions about their own health, such as access to the right information and understanding of their bodies. Misuse of health insurance in the case of hysterectomy warrants the need to revisit the design of insurance schemes in order to check for unnecessary hysterectomy. In order to combine physical and psychological well-being, there is a dire need for counselling services for women in India.

Educating women about their bodies will also enable them to exercise their rights in many other areas, such as the choice of contraceptive methods or the adoption of menstrual hygiene products. Too often, solutions are forced on them and they lack the means and knowledge to make informed decisions. Government and women's health organisations should promote a comprehensive awareness of women's health with a focus on menstrual and reproductive health

[66] Hysterectomy and urinary incontinence: a systematic review *Brown JS, Sawaya G, Thom DH, Grady D Lancet. 2000 Aug 12; 356(9229):535-9.*

[67] Psychosexual aspects of hysterectomy.*Bachmann GA Womens Health Issues. 1990 Fall; 1(1):419.*

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designed specifically for illiterate and semi-literate girls and women. Countless girls and women in rural areas, due to poor understanding of early symptoms of gynaecological problems, ignore the warning signs of their bodies and visit doctors far too late. This delay makes them much more vulnerable to drastic steps, like unnecessary hysterectomies to get rid of the pain and trouble. The government should also try to reduce the price of the Pads which is a necessity for every woman, or otherwise they should at-least try to distribute pads in areas or villages where women are not able to afford the same.

In order to combine physical and psychological well-being, there is a dire need for counselling services for women in India.

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