

MAKING INFORMED CONSENT WORK IN NIGERIAN HEALTH CARE

by

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Submitted in partial fulfilment of the requirements
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DALHOUSIE UNIVERSITY
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For my children: Mandy and Bobby

I love you both to pieces.

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Abstract

The notion of informed consent to medical treatment is a fundamental precept in law. It recognizes autonomy and the right to personal inviolability, irrespective of nationality, socio-economic situation and ideological orientation. A full realization of autonomy in the Nigerian legal system is severely constricted by sociological and cultural factors. Of particular concern is the impact of oppression which may arise from socialization, arbitrary disclosure practice by physicians, or as a result of legislative enactment. To remedy the elemental defects in the Nigerian *Code of Medical Ethics*, without addressing the impediments posed by the social environment from which a patient operates, will nuance informed consent in Nigerian health care but may not fully realize patient autonomy. A serious commitment to respecting patient autonomy may be realized through a collective effort of the State, the medical profession, the community, and patients in order to remove the impediments to full exercise of autonomy.

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Chapter One

Introduction

1.1 General Overview

The notion of informed consent to medical treatment is a fundamental precept in law. It recognizes autonomy and the right to personal inviolability, irrespective of nationality, socio-economic situation and ideological orientation. This right inures in a person by virtue of his or her individuality and appears firmly established in the legal and ethical consciousness of most developed countries. However, its necessity in a legal system which is constricted by political, economic, sociological and cultural factors appears to be largely symbolic. The concept of rights in a medical setting in Nigeria, especially one as notorious as the right to personal autonomy and self-determination, which the doctrine of informed consent connotes, is prima facie, unfeasible. This thesis critically evaluates the engagement of Nigerian law and practice with the concept of informed consent and autonomy, its challenges, and explores ways in which it may be enhanced.

Traditionally, decision-making powers in medical treatment are assigned to the physician.¹ Trained in the working of the human body and equipped with an ability to detect a medical problem and to determine how best it can be fixed, a physician is generally in a position to help a patient regain good health. The physician's commitment to care, or, at least, to do no harm, gives him or her discretion to direct a patient's course of treatment with primary focus on restoring the latter to health and physical wellness.²

In recent years, the medical profession has been confronted with increasing assertions of patients' right to make decisions concerning their care and treatment, and to control

¹ See Mary Donnelly, *Healthcare Decision-Making and the Law: Autonomy, Capacity and the Limits of Liberalism* (Cambridge: Cambridge University Press, 2010) at 11.

² Edmund D Pellegrino & David C Thomasma, *For the Patient's Good* (New York: Oxford University Press, 1988) at 7.

what happens to their bodies.³ That is, patients demand the right to be active participants in decisions about their medical treatment, reflective of their status as autonomous persons. As John Stuart Mill notes, an individual of adult years and sound mind's right over himself or herself, his or her own body and mind, is absolute.⁴

So entrenched is autonomy in healthcare discussion that it is assumed to be a basis for physicians' obligation to the patient regarding disclosure, seeking consent, confidentiality and privacy.⁵ Specifically, autonomy is identified as the value underlying the concept of informed consent. It is to allow a patient to meaningfully determine the course of his or her treatment, in line with his or her values and preferences, that knowledge and understanding of treatment alternatives and their possible risks is required.

Counterposed to autonomy is the reality of paternalism, which implies pursuing the welfare of a person without recourse to the person's opinion of what his or her best interests are. Because paternalism negates a patient's right to autonomy, and because autonomy is accepted as the most important element in the physician/patient dyad, paternalism is generally seen as a bad thing. Yet, despite the importance of autonomy, individuals are rarely, if ever, wholly rational self-rulers.⁶ An individual's self-rule is constrained, such as by environmental factors which impose conditions to which an individual has to adapt, and by cultural and social background and upbringing. Consequently, the farther a person is from being a rational self-ruler, the more paternalism seems to be morally justified.⁷ Stated simply, the amount of acceptable paternalistic intervention is inversely proportional to the degree of autonomy a person is capable of exercising.

³ Donnelly, *supra* note 1 at 13.

⁴ John Stuart Mill, *On Liberty*, 1859 (Ontario: Batoche Books Limited, 2001) at 13, available online: <http://socserv.mcmaster.ca/~econ/ugcm/3ll3/mill/liberty.pdf>

⁵ See Tom L Beauchamp & James Childress, *Principles of Biomedical Ethics* 4th ed (New York: Oxford University Press, 1994).

⁶ Erich H Loewy, *Textbook of Healthcare Ethics* (New York: Plenum Press, 1996) at 59.

⁷ Beauchamp & Childress, *supra* note 5 at 281.

In Nigeria, conflicting latent wishes find simultaneous expression in the doctrine of informed consent. The Nigerian law governing the practices of the medical and dental professions attempts, at one and the same time, to give decisional authority to patients and to maintain the authority of the physician. It acknowledges both the self-restoring power of autonomous choice and the beneficent paternalism of the medical profession. Ostensibly, emphasis on decision making in medical treatment in Nigeria has shifted from the physician to the patient. However, there is, as yet, no acknowledgement by courts in Nigeria, the Nigerian medical and dental profession, or scholarly writers, that Nigerian law has failed to place effective authority in a patient's hands, and that commitment to individual decision making in medical treatment in the country is more acknowledged than practiced.

Perhaps, confused about what the law expects them to do, Nigerian physicians have continued to exercise their traditional discretion to decide what treatment to give, what information to disclose and to which category of patients. Nigerian physicians protect themselves from any legal liability that may arise from not obtaining proper consent by the use of a generic consent form. By this form, the patient authorizes the physician not only to carry out the particular procedure indicated, but every other procedure that is medically necessary. This makes it seem that a Nigerian patient exercises autonomy, but only to the extent that he or she has chosen to seek medical treatment.

Apart from the fact that Nigerian law largely fails to ensure that patients are involved in their medical decisions, other factors also generally defeat the goal of having informed and autonomous patients. These factors derive from the socio-cultural realities of Nigeria. They include patriarchy and role-play which confine individuals to certain stereotypical conduct, and, which affect first-person decision making, especially decision making by women. This is particularly evident regarding their reproductive health.

The effect of patriarchy, socialization and role-play on the autonomous capacity of women in Nigeria is made obvious when individuals are viewed in the context of their relationships. This view, simply identified as a relational view, theory or conception,

enables a proper appreciation of the influences on a patient's autonomy, particularly, a woman's ability to determine matters relating to her reproductive health. Such matters include whether or not to have sex, use a preferred kind of contraceptives, or carry a baby to term. A relational view exposes societal valuation of women for their reproductive role, and how this influences women's decisions about sex, contraception and abortion in the country.

The influences may be direct, such as criminalizing abortion in Nigeria except to save the woman's life, or, requiring the consent and permission of her husband before accessing reproductive services. They may also be indirect, by limiting significant options that are available to them. A relational view encourages the understanding that the best response to these influences is not making the woman able to adapt to them or overcome them on a private and personal level. Rather, it involves changing the wider society which is the source of the influences.

The thesis argues, therefore, that a reasonable degree of commitment to obtaining informed consent and respecting patient autonomy in the Nigerian healthcare delivery system has untold benefits, and that these may be realized, at the policy level, by revoking legislative impediments to full autonomy, and at the social level, through empowering the citizens –actual and potential patients- educationally and economically.

1.2 Identifying the Problem

The law and practice of informed consent in Nigeria is not satisfactory. Although the right to informed consent is both constitutionally and judicially protected, it does not inform the experiences of patients. *The Code of Medical Ethics in Nigeria*⁸ straddles both paternalism and autonomy. It provides no definite guide on how, if possible, its application in medical treatment can synchronize the interest of the patient as he or she

⁸ Medical and Dental Council of Nigeria, *Code of Medical Ethics in Nigeria* (Surulere: Petruvanni, 2004) [the "Code" or the "Code of Medical Ethics."] This Code regulates the ethical conduct of the medical and dental profession in Nigeria.

sees it, with the paternalistic disposition of the medical profession toward the patient. This incongruity is maintained by other ancillary provisions in the *Code*.

Given to operate in a socio-cultural context that appears detrimental to patient autonomy, the observance of informed consent within the Nigerian medical setting appears to be arbitrary, although, as a theory, it appears to be well understood. In practice, consent is not generally obtained before every medical procedure, and informed consent is not always sought. Whether or not necessary information is disclosed to the patient depends on the patient's literacy level. Because of Nigeria's patriarchal social order, authorization of a competent woman's medical treatment may be obtained from her husband.

1.3 Thesis Objective

In light of the foregoing, this thesis critiques the law and practice of informed consent in Nigeria. It examines the shortcomings of its prescriptive content, and the challenges to operationalizing informed consent in Nigeria. In the end it suggests that the concept may be read and interpreted in more nuanced ways to account for the socio-economic and cultural realities of a Nigerian patient. The thesis seeks to answer three basic questions: how does the practice of informed consent promote a Nigerian patient's autonomy? What does autonomy mean to a Nigerian patient, and how effectively is it being exercised? How can a Nigerian patient's autonomy be maximized?

This inquiry necessitates an exposition of the peculiarities in the socio-cultural life of Nigerians. Specifically, the exposition depicts Nigeria as performing below optimum in regard to rights entitlements. The analysis demonstrates that, in principle, the notion of patient autonomy is acknowledged in Nigerian healthcare; however, it hardly forms part of the experience of patients. Nevertheless, the thesis shows that the right to autonomy is important. As such, it delineates ways in which its realization may be contextualized within the realities of Nigerian medical practice, specifically, in terms of its manifestation in the dynamics of the doctor/patient relationship.

To do this, the thesis draws on the limited literature on informed consent in Nigeria. Most of this deals with empirical studies of how informed consent is perceived and practiced in Nigeria,⁹ and with the sociological and cultural situations in Nigeria which make the practice of informed consent different from what is generally understood to be the practice in other jurisdictions.¹⁰ Some of the literature also deals with the need to extend the informed consent doctrine to apply to alternative medical therapies.¹¹ Thus, while factual accuracy is a general concern, this thesis is constrained by inadequacy of local material.

1.4 Theoretical Framework

Informed consent primarily seeks to protect the autonomy of patients. There are several conceptions of autonomy.¹² In Gerald Dworkin's classic exposition, autonomy is "liberty" or "freedom to act", as well as "dignity" and "freedom of the will". It is also

⁹ See for example, OC Osime *et al*, "Current Practices and Medico-Legal Aspects of Pre-Operative Consent" (2004) 81:7 East African Medical Journal 331; NJ Jebbin & JM Adotey, "Informed Consent: How Informed Are Patients?" (2004) 13 Nigerian Journal of Medicine 148; OI Aisuodionoe-Shadrach, OS Ogunlade & OE Amoran, "An evaluation of the Informed Consent Process for Elective Surgery at a University Hospital" (2006) 15 Nigerian Journal of Medicine 281; KA Agu, "Informed Consent Policy and Surgeons in Southeast Nigeria" (2003) 9 Nigerian Journal of Surgery 39; AO Adisa *et al*, "Informed Consent in Surgery: An Audit of Practice in Ile-Ife, Nigeria" (2008) 11(3) Nigerian Journal of Clinical Practice 206; Temidayo O Ogundiran & Clement A Adebamowo, "Surgeons' Opinions and Practice of Informed Consent in Nigeria" (2010) 36:12 J Med Ethics 741.

¹⁰ See for example Emmanuel R Ezeome & Patricia A Marshall, "Informed Consent Practices in Nigeria" (2008); David O Irabor & Peter Omonzejele, "Local Attitudes, Moral Obligation, Customary Obedience and Other Cultural Practices: Their Influence on the Process of Gaining Informed Consent for Surgery in a Tertiary Institution in a Developing Country" (2009) 9:1 Dev World Bioeth, 34; YZ Lawal *et al*, "The Doctrine of Informed Consent in Surgical Practice" (2011) 10:1 Annals of African Medicine 1.

¹¹ See for example Ireh Otighbor Iyioha, "Informed Choice in Alternative Medicine: Expanding the Doctrine Beyond Conventional Alternative Therapies" (2007) 5:2 ICFAI Journal of Health Care Law [Iyioha, "Informed Choice in Alternative Medicine"].

¹² Alasdair Maclean, *Autonomy, Informed Consent and Medical Law: A Relational Challenge* (Cambridge: Cambridge University Press, 2009) at 9.

“independence”, and the faculty of “critical reflection”.¹³ Alasdair Maclean adds that autonomy is “self-mastery”; “choosing freely”; “choosing one’s own moral position and accepting responsibility for one’s choice”; “self-control”; and “self-determination”.¹⁴ These various notions of autonomy reflect its core concept which is implicit in its etymology: self-government.

The conception of the self that exists in Nigeria is a relational one. There, individuals are socially interconnected, mutually interdependent, socially and culturally encumbered, and affectionate. It is proper that the notion of autonomy that is used in exploring the concept of informed consent in Nigerian healthcare be one that reflects the social and cultural constitution of individuals. This enables proper appreciation of the factors within the society which either enhance or oppress the individual and his or her autonomous capacity.¹⁵ A relational view of autonomy provides an appropriate theoretical framework. It depicts the socio-culturally and politically situated positions from which individuals exercise, or seek to exercise control over their health. In essence, it focuses on what the effects are of being in relation.

As mentioned above, among the benefits of relational autonomy include the fact that it enables analysis of impediments to and facilitators of autonomous agency.¹⁶ They include patriarchy, gender inequality and religion, on the one hand, and familial support, empathy, and the sense of being connected with others, on the other hand. Particularly, relational autonomy enables analysis of the ways in which oppressive socialization and social relationships can impede autonomous agency.¹⁷ According to Mackenzie and Stoljar, the impediments are visible at three interrelated levels: first, at the time of

¹³ Gerald Dworkin, *The Theory and Practice of Autonomy* (Cambridge: Cambridge University Press, 1988) at 6 [*Theory and Practice of Autonomy*].

¹⁴ Maclean, *supra* note 12 at 10.

¹⁵ See Jocelyn Downie & Jennifer Llewellyn, “Relational Theory & Health Law and Policy” (2008) Special ed Health L J 193.

¹⁶ Catriona Mackenzie & Natalie Stoljar, “Introduction: Autonomy Refigured” in Catriona Mackenzie & Natalie Stoljar eds, *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self* (New York: Oxford University Press, 2000) 3 at 22.

¹⁷ *Ibid.*

formation of the individual's desires, values and beliefs; second, at the time of development of autonomous capacity, self-reflection, self-direction, and self-knowledge; and, third, at the time of acting on autonomous desires or making autonomous choices.¹⁸ Since the ultimate thesis of this paper is that true operationalization of informed consent is viable if patients are empowered, and the impediments to their exercise of autonomy are removed, an anti-oppressive relational theory is ideal as a framework. In essence, where oppression is perceived, this thesis argues for liberation.

A major challenge of this framework, perhaps the only one, is that it may lead to disruption of relationships, particularly intimate relationships like family, marriage and church. However, a disruption may be salutary, desired even, if by it, the autonomous capacity of certain individuals to make their own healthcare decisions is enhanced.¹⁹ This is very important because the capacity to be autonomous is, according to Marilyn Friedman, "instrumentally valuable as a means for resisting oppression and intrinsically valuable as part of the fullest humanly possible development of moral personality."²⁰

1.5 Thesis Roadmap

The issues arising from the law and practice of informed consent in Nigeria are discussed over four substantive chapters. Broadly speaking, the two chapters following this introduction engage with the general concept of informed consent: its nature, importance, history and constitutive elements. Chapters Four and Five are, respectively, concerned with the Nigerian law on the concept and its shortcomings, and the challenges to implementing informed consent in the country. The content of these chapters is summarized as follows.

¹⁸ *Ibid.*

¹⁹ See generally, Marilyn Friedman, "Autonomy, Social Disruption, and Women" in Catriona Mackenzie & Natalie Stoljar, eds, *Relational Autonomy: Feminist perspectives on Autonomy, Agency, and the Social Self* (New York: Oxford university Press, 2000) 35 at 41-48.

²⁰ *Ibid* at 47.

Chapter 2 examines the concept of informed consent. It describes its nature and importance in the protection of bodily integrity and its invocation of the ethical values of beneficence and autonomy. It explores the modern history of the concept, beginning from the Nuremberg events of 1947. It traces the extension of its elements to the clinical setting, and highlights the judicial decisions instrumental in its extension. It concludes that although physicians have a professional obligation to promote the welfare of patients, it is important that patients are empowered to be able to decide on the medical treatment that they receive. Doing this will guard against possible misuses of professional power, protect patients from being taken advantage of by physicians, and respect their right to medical self-determination.

Chapter 3 analyzes the constitutive elements of informed consent, namely, competence, voluntariness and disclosure. As to their determination, the analysis, in regard to competence, suggests a functional assessment which is not based on age or mental status, but on the patient's ability to understand and appreciate the consequences of any decision that is made. As to voluntariness, it argues that this depends on the intentionality or deliberateness of the patient's decision, and on the absence of fraud, duress, undue influence, misrepresentation and oppression. In regard to disclosure, it suggests that its adequacy and materiality should be determined by the need of the patient, including his or her understanding of the information given. It also suggests that understanding may be ensured or enhanced through a hermeneutic approach which encourages an engagement with patients in ways that facilitate their understanding of the information disclosed.

Chapter 4 begins the exploration of informed consent in Nigeria. First, it analyzes the law, that is, the regulatory framework of medical and dental practice in Nigeria which includes the *Constitution of the Federal Republic of Nigeria 1999*, judicial decisions, and the *Code of Medical Ethics*. It also examines the actual practice of informed consent. It argues that the right of self-determination is adequately reflected in the constitutional

rights of personal dignity, personal liberty, right to privacy, and freedom of conscience and religion, especially as interpreted by the court. It finds that the *Code of Medical Ethics* may not adequately cater to the particular needs of Nigerian patients in terms of alternatives to treatment. The *Code of Medical Ethics* also does not adequately reflect the social context in which Nigerian patients must operate: the framework does not help to identify who may act as next of kin where a substitute decision is required and what considerations should guide him or her. It finds that the elements of informed consent are not well delineated, and that there is a conflict about where decisional authority resides. The analysis establishes that the inadequacies of the *Code of Medical Ethics* promote the arbitrariness observable in the practice of informed consent in Nigerian healthcare. To deal with this unsatisfactory situation, the discussion suggests that the decision making process should be collaborative, although the patient's preference should prevail; competence should be functionally assessed and materiality of disclosure should be tied to the patient's needs; alternatives to treatment should include indigenous alternatives, particularly where there is evidence of their efficacy; that next-of-kin should include close friends, even if they are not related to the patient, and family members may persuade the patient, but the decision should be his or hers.

Chapter 5 examines socio-cultural factors which affect the practice of informed consent in Nigeria. Unlike Chapter 4, this chapter concentrates on factors external to the *Code of Medical Ethics* and their influences on the way informed consent is practiced. The factors, which are mainly cultural, are not all peculiar to Nigeria. However, they appear to be more nuanced in the country and include patriarchy, religion, and stereotypical roles. Their combined impact, especially in regard to female patients, is that first person consent may not be obtained in practice, and autonomy may be desirable to have, but difficult to attain except through empowerment.

The conclusion (Chapter 6) argues that in light of the inadequacies of current informed consent practice and the challenges to its proper functioning posed by the socio-cultural and economic realities of Nigeria, a realistic means to foster progress is to change the

wider social environment in which decisions are made. This may be done through empowering citizens - actual and potential patients - economically and educationally, and reversing the effect of socialization through targeted education, regardless of gender. This empowerment must be culturally based to be effective. Accordingly, it must engage the traditional decision makers and develop allies among those who are likely to benefit from a patriarchal society. In all of these, the care and support that is visible in community-oriented Nigeria should be recognized and upheld.

Chapter Two

History and Importance of Informed Consent in Health Care

2.0 Introduction

The notion of formal informed consent in healthcare is a relatively recent development. Traditionally, when patients accessed medical treatment, they expected to be relieved of their illness by physicians who are sworn to protect their health and wellbeing. They also accepted the unequal relationship they were entering into. Without patients submitting to treatment, physicians, typically, cannot administer treatment. This implies the existence of a form of consent. However, the nature of the consent was usually not formal, in the sense of being express, and certainly not as informed as is currently demanded. As medicine advanced and society developed, a need for formal and informed consent²¹ of patients before treatment was felt. The importance of obtaining consent at all, and informed consent in particular, is the focus of this chapter.

This Chapter traces the modern history of informed consent to the Nuremberg trial where the elements that make up informed consent were articulated, albeit, in a research setting. This historical account brings into focus the factual basis for informed consent. It reinforces the importance of informed consent by highlighting the possibility of abuse by physicians, of their privileged position. It traces how the consent elements were expanded, reinterpreted and extended, in the form they currently are, to the clinical setting, and the role played by the courts. It concludes that autonomy through informed consent is very important in modern bioethics and deserves protection.

²¹ Throughout this thesis, “informed consent” will be used inclusively and encompasses informed decision making and informed choice. The term is retained because of its popularity and for ease of recognition.

2.1 Authorization for Treatment: Consent Simpliciter

Generally, the right of competent persons to refuse or consent to medical treatment is a basic premise in modern medical ethics and law. To impose treatment, however beneficial, on a competent patient without his or her permission or authorization is both unethical and, often times, unlawful except where such permission cannot be obtained²² or is not required.²³ This requirement for self-determination is founded on respect for a person's right to autonomy and the inviolability of bodily integrity.²⁴ Aside from these ethical reasons, failure to obtain the consent of a patient before treatment opens a physician to a legal claim in damages for trespass against the patient, specifically, a claim in battery. Cardozo J aptly captured the legal essence of consent to treatment in his classic statement thus:

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

²² Emily Jackson, *Medical Law: Text, Cases and Materials* 2nd ed (Oxford: Oxford University Press, 2010). The earliest reported case which dealt with consent to treatment is generally acknowledged to be the English case of *Slater v Baker & Stapleton*, [1767] 95 Eng Rep 860 (KB). But non-consensual medical treatment has long before then been remediable under a writ of trespass. See President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research, *Making Health Care Decisions: The Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship* Volume One: Report (Washington DC: US Government Printing Office, 1982) at 16 (footnote 3) [President's Commission Report].

²³ An example is where public health legislation authorizes treatment without the patient's consent. See for example, Alberta *Public Health Act*, SA 1984, c P-27, s 31 [am 1988, c 41, s 9].

²⁴ See *Ciarlariello v Schacter*, [1993] 2 SCR 119 at 135 [*Ciarlariello*]. See also Owena Simpson, "Consent and Assessment of Capacity to Decide or Refuse Treatment" (2011) 20:8 *British Journal of Nursing* 510; Margaret Somerville, "Changes in Mental Health Legislation as Indicators of Changing Values and Policies" in Martin Roth & Robert Bluglass, eds, *Psychiatry, Human Rights and the Law* (Cambridge: Cambridge University Press, 2009) 167.

without his patient's consent commits an assault for which he is liable in damages.²⁵

In *Schloendorff v Society of New York Hospital*, the plaintiff consented to an ether examination to determine the character of a lump that was found in her stomach. According to her, she did not consent to the operation that was subsequently carried out to remove the lump which turned out to be a fibroid tumour. Following the operation, and, according to the testimony of her witnesses, because of it, she developed gangrene in her left arm and some of her fingers had to be amputated. She sued the hospital, which was run as charity, for her injury. The court noted that, if the plaintiff's testimony that she did not consent to the operation is accurate, it is battery and liability will be affixed on the physicians who carried out the operation. However, the plaintiff was unable to recover damages because her claim was against the hospital instead of the physicians. For, as the court held, hospitals that are maintained as charitable institutions are not liable for the acts of the doctors they employ. The policy reason for this, as the court found, is that to impose liability may constrain charitable institutions, as a measure of self-protection, to limit their activities. Therefore, although the plaintiff lost, it was primarily because her claim was against the hospital. Arguably, if she had sued the operating physician, and had been able to establish that she did not consent to the operation, she would have succeeded in proving battery.

The nature of consent required for a defense against battery is not particularly exacting. It could be given expressly in writing or words, implied from conduct or inferred from circumstances.²⁶ It suffices if the consent was given based on the name and a general

²⁵ *Schloendorff v Society of New York Hospital*, 211 NY 125, 105 NE 92 (1914) [*Schloendorff*].

²⁶ Simpson, *supra* note 24.

description of the procedure by a competent patient.²⁷ This means that it is not overly concerned with the quality of the patient's understanding, nor does it require strenuous disclosure from the physician.²⁸ However, consent would be vitiated by fraud, coercion or deception.²⁹

The requirement of consent demonstrates and protects the importance of the right of bodily integrity and self-determination. Therefore, where consent is lacking, or exceeded, a patient may recover damages, notwithstanding that the treatment or surgery was competently performed, and notwithstanding that the patient actually benefitted by it. This was, arguably, the situation in the Canadian case of *Malette v Shulman*.³⁰

In *Malette v Shulman*, the plaintiff was taken unconscious to the hospital following an accident in which the car she was in, as a passenger, and which was driven by her husband, had a head-on collision with a truck. The accident resulted in the immediate death of the plaintiff's husband, and left the plaintiff severely injured and bleeding. A card declaring her status as a Jehovah's Witness and refusing blood treatment was found on her. The fact of the card and its content was communicated to the defendant physician attending her. Despite the card, the defendant physician administered blood to the plaintiff. Following the transfusion, the plaintiff's condition improved and she was subsequently discharged from the hospital. The Defendant was held to have violated the patient's right to bodily integrity.

This case laid a very strong emphasis on a patient's right to self-determination. It equated individual freedom of choice and self-determination with fundamental

²⁷ See *Chatterton v Gershon*, [1981] 1 QB 432, [1981] 1 All ER 257 [*Chatterton*]. See also *Reibl v Hughes*, [1980] 2 SCR 880 [*Reibl*].

²⁸ President's Commission Report, *supra* note 22 at 19.

²⁹ See generally Jackson, *supra* note 22.

³⁰ *Malette v Shulman*, [1990] OJ No 450, (1990), 67 DLR (4th) 321 (Ont CA) [*Malette*].

constituents of life, and demonstrated that to deny individuals the freedom to choose their healthcare lessens their value of life rather than enhances it.³¹ As a result, although the plaintiff recovered after the blood transfusion administered by the defendant, perhaps because of the blood transfusion, the defendant was still found liable in battery.

2.1.1 *Exceptions to the Requirement of Consent*

Generally, the consent of a patient must be sought in every case before any medical intervention may be administered. However, there are occasions when it may be impossible or unnecessary to obtain the consent of the patient. These include emergency situations, for example, where the patient is unconscious.³² Or, where, in the interest of public health, such medical intervention is required to be carried out.³³ In the case of emergencies, a doctor is justified in proceeding without the patient's consent on the basis of necessity.³⁴ However, the treatment administered must be to preserve the life or health of the patient.³⁵ The emergency exception does not extend to treatment that is administered because it is convenient to do so, either because the patient is unconscious, or is under anaesthetic.³⁶ Patients who are unable to provide consent to

³¹ *Ibid* at 35.

³² For example, *Parmley v Parmley*, [1945] 4 DLR 81 (SCC).

³³ Erin Nelson, "The Fundamentals of Consent" in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds, *Canadian Health Law and Policy* 2nd ed (Canada, Butterworths, 2002) 111 at 117-20.

³⁴ Simpson, *supra* note 22. It is suggested that justification for treating without consent in emergency situation is based on implied consent, that is, the assumption that the patient would have consented to such emergency treatment. For a fuller discussion, see PDG Skegg, "A Justification for Medical Procedures Performed without Consent" (1974) 90 LQ Rev 512. In *Malette*, *supra* note 30 at para 20, the court indicated its preference for necessity over implied consent, but held that no matter the justification, the effect of emergency is to set aside the legal requirement of consent on the basis that, being a reasonable person, the patient would want emergency aid to be given to him or her if he or she is incapable of giving instruction.

³⁵ *Marshall v Curry* (1933), 3 DLR 260 (NSSC).

³⁶ *Murray v McMurchy* (1949), 2 DLR 442 (BCSC). *c/f Re F*, [1990] 2 AC 1 (HL) where the House of Lords held that if a patient is incapable of consenting, the physician may

treatment may have their next-of-kin or other persons make decisions on their behalf. However, where the next of kin is not immediately available, and postponing the treatment will result in greater harm, the emergency principle may apply.³⁷

2.2 Knowledge and Consent: The Doctrine of Informed Consent

For a person to meaningfully consent to a medical procedure, it is necessary that he or she knows the implications of his or her decision. Consequently, the physician, as part of his or her duty of care, is obligated to provide the patient with material information required for an enlightened decision about his or her medical treatment. This is the doctrine of informed consent.

Informed consent is the primary means of protecting a patient's right to control his or her medical treatment.³⁸ Under this doctrine, a physician may not administer any treatment on a patient unless he or she consents. A valid consent which will protect a physician from liability, is one given, following adequate provision of information, and understanding of it, which enables a patient to evaluate the risks and benefits of a proposed treatment, and available treatment options, in order to make a choice whether or not to submit to the treatment.³⁹ The doctrine anticipates that the patient has the capacity to understand the information that is supplied, that he or she actually understands it to a reasonable extent, and that he or she is able to make a reasoned decision based on the facts.

administer any treatment he or she considers to be in the patient's best interest, so long as the treatment is reasonable in the circumstances. This case has been criticized as endorsing paternalism. See, for example, Phil Fennel, "Inscribing Paternalism in the Law: Consent to Treatment and Mental Disorder" (1990) 17 JL & Soc'y 29.

³⁷ See *Health Care Consent Act*, SO 1996, s 25(2) [being Schedule A to the Advocacy, Consent and Substitute Decisions Statute Law Amendment Act, SO 1996, c 2; proclaimed in force March 29, 1996]. The authorization of the most senior doctor in the medical establishment may be required. See *Code of Medical Ethics in Nigeria*, *supra* note 8 s 19, discussed in Chapter Four.

³⁸ *Malette*, *supra* note 30 at para 18. This is not limited to accepting or refusing treatment, but includes the decision about what treatment to accept from available options.

³⁹ *Videto v Kennedy* (1981), 125 DLR (3d) 127, (1981) 33 OR (2d) 497.

Erich Loewy opines that consent implies a fiduciary relationship that assumes that what will be done is for the patient's good and that the patient consents because he or she understands what is to be done, the means, and the intended goal.⁴⁰

In *Reibl v Hughes*,⁴¹ the court described this as the right of the patient to know the risks attendant upon any option of treatment to effectively decide which one to take. This imposes an obligation on the physician to provide the patient with the information he or she needs for an informed consent.⁴² This obligation forms part of the physician's duty of care to the patient. Jay Katz noted that "[p]roceeding from the law of battery, the courts reasoned that significant protection of a patient's right to decide their medical fate required not merely perfunctory assent but a truly "informed consent," based on an adequate understanding of the medical and surgical options available to them."⁴³ Where a physician fails to disclose, or to adequately disclose, information which is necessary for a patient to be able to decide the course of treatment to adopt, the physician is said to be in breach of his or her duty of care, and, where harm results which can be linked to the lack of or insufficient disclosure, the physician may be liable in negligence.⁴⁴

2.2.1 *Informed Refusal*

Although suggested by the nomenclature, informed consent is not limited to instances where a patient accepts treatment. It also extends to the right to refuse medical treatment in exercise of a patient's right over his or her own body.⁴⁵ A competent

⁴⁰ Loewy, *supra* note 6 at 115.

⁴¹ *Reibl*, *supra* note 27.

⁴² *Ibid.* See also *Hopp v Lepp*, [1980] 2 SCR 192.

⁴³ Jay Katz, "Informed Consent A Fairy Tale?: Law's Vision" (1977) 39:2 U Pitt L Rev 137 at 148.

⁴⁴ See *Reibl*, *supra* note 27; *Canterbury v Spence*, 464 F2d 772 (DC Cir 1972) [*Canterbury*]; *Chatterton*, *supra* note 27; *Rogers v Whittaker*, [1992] HCA 58, (1992) 175 CLR 479. South Africa allows a cause of action in battery where failure of informed consent is alleged. See *Castell v De Greef*, 1994 (4) SA 408 (c). This case was challenged in *Broude v McIntosh*, 1998 (3) SA 69 (SCA) but the decision in *Castell* was not overturned.

⁴⁵ See *Malette*, *supra* note 30 at para 19.

patient has a right to choose one treatment instead of another, and to refuse any medical treatment, regardless of the consequences of such refusal, and regardless of how beneficial the proposed treatment may be. This is because the right to be free from non-consensual medical treatment is an implicit component of the right to determine what happens to one's body, which underlies the doctrine of informed consent.⁴⁶ Except in very limited instances, such as emergency situation or public health requirement, the right of a person over his or her body is absolute.⁴⁷ The right of patients to refuse treatment is so fundamental that, aside from judicial recognition, it also enjoys constitutional protection, especially constitutional provisions dealing with the right to liberty and security of the person.⁴⁸

Withholding or withdrawing treatment upon the decision of a patient, even if it is a life-saving treatment, does not result in a liability on the part of the physician.⁴⁹ On the other hand, imposing treatment in the face of patient refusal may result in liability for battery. However, the physician has a legal duty to ensure that the refusal is not as a result of a failure of the communication process, and that the patient understands the consequences of refusing treatment.⁵⁰ Where a patient refuses necessary treatment, it

⁴⁶ See *Fleming v Reid* (1991), 82 DLR (4th) 298.

⁴⁷ See *Ciarlariello*, *supra* note 24 at 618-619; *Rodriguez v British Columbia (Attorney General)* (1993), 107 DLR (4th) 342 at 398-99; *Airedale NHS Trust v Bland*, [1993] AC 789 at 864 (HL).

⁴⁸ See the American case of *Cruzan v Director, Missouri Department of Health*, 497 US 261 (1990) where the right to refuse treatment was recognized under the liberty interest protected by the 14th Amendment to the American Constitution.

⁴⁹ See *Nancy B v Hotel-Dieu de Quebec* (1992), 86 DLR (4th) 385 (Que SC); *Manoir de la Pointe Bleue, (1978) Inc v Corbeil*, [1992] RJQ 712 (SC) discussed in Joan Gilmour, "Withholding and Withdrawing Life Support from Adults at Common Law" (1993) 31 Osgoode Hall LJ 473 at 494-95.

⁵⁰ Whether informed consent extends to informed refusal was left inconclusive in *Malette*, *supra* note 30. The trial court [1987] OJ No 1180 at 114-15, had held that the right to refuse treatment is not premised on an understanding of risks of refusal. But, The Ontario Court of Appeal noted that a corollary of the right to consent to treatment is the right to refuse treatment. It did not state whether there is a duty on the physician to ensure that the patient understands the risk of refusing treatment. However, it is well established that a physician has a duty to ensure that the patient understands the

is prudent to have it documented, including the steps taken to ensure that the patient understands the consequences of refusing treatment. This will serve an evidential function in the event that a dispute arises.⁵¹

2.3 The Nuremberg Experience: Historical Overview of the Spirit and Intent of Informed Consent

Contemporary discussion of informed consent in biomedicine started with the 1947 Nuremberg focus on research ethics.⁵² However, its principles and elements also apply in clinical ethics. How this came about is the focus of the rest of this chapter. The historical overview covers the factual basis of the Nuremberg Code, its consent requirement, its modification by subsequent ethical documents, and, finally, its extension to clinical ethics through the court.⁵³ The historical account buttresses the importance of informed consent as already discussed, and emphasizes the danger of not insisting on informed consent.

2.3.1 *The Nuremberg Experience*

As noted, modern judicial development of informed consent in medical treatment was presaged by the articulation of consent requirements in the context of research involving human subjects. The articulation was to address the stark and horrifying account of the atrocities perpetuated by Nazi physicians under the guise of medical

risks of refusing treatment. See *Truman v Thomas*, 165 Cal Rptr 308 (Cal SC 1980); *Hollis v Dow Corning Corp* (1995), 129 DLR (4th) 609 at 620 (SCC); *Re T (Adult: Refusal of Medical Treatment)*, [1992] 4 All ER 649 at 663 [*Re T*]; *Reibl*, *supra* note 27 at 13.

⁵¹ See *Davidson v British Columbia*, [1996] 1 WWR 137 (BC SC) where it was held that failure to document the patient's refusal and the explanations of the risks of refusing treatment is not negligent but only affects the ease of proof.

⁵² Neil C Manson & Onora O'Neill, *Rethinking Informed Consent in Bioethics* (Cambridge: Cambridge University Press, 2007) at 4.

⁵³ See generally, President's Commission Report, *supra* note 22 at 20 [footnote 19]. It should be noted that prior to the first modern case on informed consent in 1957, there were cases that referred to the duty of doctors to warn patients of risks or dangers of treatment. Such cases include *Hunter v Burroughs*, 123 Va 113, 96 SE 360 (1918); *Pratt v Davis*, 224 Ill 300, 79 NE 562 (1906), *aff'g* (1905) 118 Ill App 161 (cited in President's Commission Report, *supra* note 22 at 19 [footnote 14]).

research during World War II.⁵⁴ The central factor in the account is that the atrocities were performed on non-consenting prisoners. The defense, unsuccessfully, tried to persuade the tribunal that the absence of positive evidence that the prisoners refused to participate suggests they consented.⁵⁵

The experiments included military-related studies to test the limits of human endurance to high altitudes and freezing temperatures. There were medically related experiments which involved inoculating prisoners with infectious disease pathogens, and testing new antibiotics on non-consenting prisoners. There were also various mutilating bone, muscle, and nerve experiments, as well as sterilization experiments all performed on non-consenting prisoners.⁵⁶

The final judgment of the tribunal that tried the offending Nazi doctors contained ten principles which became the Nuremberg Code. These principles specifically address the scope and limit of acceptable non-therapeutic experimentation on adult prisoners. Because this group of persons, though competent, is in confinement, the Nuremberg Code was particularly concerned about elements of coercion and duress. As a result, informed consent became the mechanism for ensuring that whatever consent that was obtained from these persons was voluntary, free from coercion, and given with full

⁵⁴ President's Commission Report, *ibid* at 20.

⁵⁵ *Trials of War Criminals Before the Military Tribunals Under Control Council Law 10*, vol II (Washington, DC: Superintendent of Documents, US Government Printing Office, 1950) Military Tribunal, Case 1, United States v Karl Brandt et al, October 1946-April 1949 at 53-56.

⁵⁶ For a fuller account of the Nazi medical atrocities, see *Trials of War Criminals Before the Military Tribunals Under Control Council Law 10*, vol 1 (Washington, DC: Superintendent of Documents, US Government Printing Office, 1950) Military Tribunal, Case 1, United States v Karl Brandt et al, October 1946-April 1949, at 27-74; Telford Taylor, "Opening Statement of the Prosecution December 9, 1946" in George J Annas & Michael A Grodin, eds, *The Nazi Doctors and the Nuremberg Code: Human Right in Human Experimentation* (New York: Oxford University Press, 1992) 67; Michael Burleigh, *Death and Deliverance: 'Euthanasia' in German, c 1900-1945* (Cambridge: Cambridge University Press, 1994); *Ethics and Extermination: Reflections on Nazi Genocide* (Cambridge: Cambridge University Press, 1997).

knowledge of the implications of the research project.⁵⁷ The first principle of the Nuremberg Code, devoted primarily to informed consent, provides as follows:

The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, over-reaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision. This latter element requires that before the acceptance of an affirmative decision by the experimental subject there should be made known to him the nature, duration, and purpose of the experiment; the method and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and the effects upon his health or person which may possibly come from his participation in the experiment.

A valid consent is, therefore, one which has all the qualities prescribed above: competent person; full disclosure; and, voluntariness. The requirement of voluntariness reflects the social contract tradition which recognizes, in a research context, that no injury is done where the subject is willing.⁵⁸ The proscription of force, fraud, deceit, duress, over-reaching or other form of constraint is to assure that the consent obtained is voluntary. This protects the right of the individual, as an autonomous person, to decide, following an evaluation of the burdens of the endeavor, whether or not to participate in any research project, and the extent of participation.⁵⁹

The Nuremberg Code does not indicate whether persons who are unable to give informed consent can, nevertheless, participate in a research project by having someone else give consent on their behalf. This is significant because the testimony on

⁵⁷ Michael A Grodin, "Historical Origins of the Nuremberg Code" in George J Annas & Michael A Grodin, eds, *The Nazi Doctors and the Nuremberg Code: Human Right in Human Experimentation* (New York: Oxford University Press, 1992) 121 at 138.

⁵⁸ Manson & O'Neill, *supra* note 52 at 3.

⁵⁹ See Leonard H Glantz, "The Influence of the Nuremberg Code on U.S Statutes and Regulations" in George J Annas & Michael A Grodin, eds, *The Nazi Doctors and the Nuremberg Code: Human Right in Human Experimentation* (New York: Oxford University Press, 1992) 183 at 184.

ethically acceptable research, given by the expert witnesses for the prosecution at the trial influenced, to a significant extent, the articulation of the principles of the Nuremberg Code.⁶⁰ According to this testimony, where a subject is mentally ill, and the experiment concerns the nature and treatment of nervous and mental illness, consent may be given by the next of kin or legal guardian. And where possible, the consent of the subject should also be obtained.⁶¹

In their final judgment, the tribunal expanded on the testimony of the expert witnesses. However, it did not discuss the requirement of substitute consent in the case of mentally ill subjects. This may be interpreted to mean that the tribunal does not envisage incompetent subjects being used for research purposes, as they are incapable of understanding the risks and providing informed consent. Alternatively, the omission may be because the situation where incompetent persons were experimented upon was not before the tribunal. Hence, it did not see any need to address it.

2.3.2 *The Nuremberg Code and Subsequent Ethical Documents*

Following the articulation of the principles of the Nuremberg Code, a series of international documents were created, each traced to the Nuremberg Code, and each proscribing experiments on human subjects without the subject's informed consent.⁶² The Nuremberg Code also influenced the activities of the World Medical Association [WMA], which was founded in 1947, in the formulation of its ethical guidelines.

⁶⁰ Grodin, *supra* note 57 at 135.

⁶¹ *Ibid.*

⁶² See for example, the *International Covenant on Civil and Political Rights* G A Res 2200 A, 21 UN GAOR Supp (No 16) 49, UN Doc A/6316 (Dec 16, 1966); the four Geneva Conventions of August 1949: *Convention for the Amelioration of the Condition of the Wounded and Sick in armed Forces in the Field*, 75 UNTS 31; *Convention for the Amelioration of the Condition of the Wounded, Sick and Shipwrecked Members of Armed Forces at Sea*, 75 UNTS 85; *Convention Relative to the Treatment of Prisoners of War*, 75 UNTS 135; *Convention Relative to the Protection of Civilian Persons in Times of War*, 75 UNTS 287.

The factual basis of the Nuremberg Code influenced the development of codes and guidelines, both in the general field of medical ethics, and in research involving human subjects.⁶³ It impelled the WMA Assembly in Geneva, to rededicate physicians to the ethics of medicine in what became known as the Declaration of Geneva, a modern restatement of the Hippocratic Oath.⁶⁴

2.3.3 *Substitute Consent and Adequate Disclosure*

The most significant aspect of the Nuremberg Code for this thesis, is its informed consent provision in Principle 1, as set out above. This provision has also received the most criticism. For example, it is argued that its absolute prescription for the voluntary and informed consent of the subject forecloses research on the mentally incompetent and children, people who are unable or legally incapable of providing consent.⁶⁵ Also criticized is its requirement of full disclosure. It is argued, first, that it is impossible for a researcher to provide comprehensive information on every possible risk, for in most cases, such risks are not known until the experiment is actually conducted. Second, many of the procedures and drugs used in the research are too technical for the research subjects to understand either the effects of the treatment or the risks involved.⁶⁶ Thus, it was suggested that the experimenter should only strive towards adequate understanding by the subject. The principle was therefore restated to be one of a duty to disclose adequate information, not a duty to achieve full understanding in every subject.⁶⁷

⁶³ See generally, Sharon Perley *et al*, "The Nuremberg Code: An International Overview" in George J Annas & Michael A Grodin eds *The Nazi Doctors and the Nuremberg Code: Human Right in Human Experimentation* (New York: Oxford University Press, 1992) 149.

⁶⁴ *Ibid* at 154.

⁶⁵ *Ibid* at 155.

⁶⁶ *Ibid* at 156; World Health Organization (WHO) and the Council for International Organizations of Medical Sciences (CIOMS) *Proposed International Guidelines for Biomedical Research Involving Human Subjects* (Geneva: CIOMS, 1982), General Survey at 8.

⁶⁷ Perley *et al*, *supra* note 63 at 156, quoting Henry Beecher, "Some Guiding Principles for Clinical Investigation," (1966) 195 JAMA 157.

2.3.4 *Guidance of Physicians by Physicians: From the Nuremberg Code to the Helsinki Declaration*

The short-comings of the Nuremberg Code highlighted the need for more extensive guidelines, one designed by physicians for physicians, to regulate the conduct of therapeutic and non-therapeutic experiments, unlike the Nuremberg Code which only regulates non-therapeutic experiments. In 1961, the Committee on Medical Ethics of the WMA submitted its proposal for a code of ethics for human experimentation to the WMA at its 15th General Assembly. After several revisions, the proposal was adopted by the 18th World Medical Assembly in Helsinki in 1964.⁶⁸ The 1964 Declaration of Helsinki reiterated the requirements of the Nuremberg Code. However, it went two steps further than the Nuremberg Code: First, it provides for situations where the research subject is legally or physically unable to provide consent, in which case the consent of a legal guardian will be sufficient. Second, it requires consent to be in writing.

2.3.5 *From Research Ethics to Clinical Ethics through the Courts*

Prior to the articulation of the Nuremberg Code, common law acknowledged the fundamental right of an individual to control what is done to his or her body. It also established the duty of the physician to seek the consent of their patient prior to initiating treatment. Several of the cases decided around this time, including

⁶⁸ The Declaration of Helsinki was adopted by the 18th WMA General Assembly, Helsinki, Finland, June 1964, and amended by the: 29th WMA General Assembly, Tokyo, Japan, October 1975; 35th WMA General Assembly, Venice, Italy, October 1983; 41st WMA General Assembly, Hong Kong, September 1989; 48th WMA General Assembly, Somerset West, Republic of South Africa, October 1996; 52nd WMA General Assembly, Edinburgh, Scotland, October 2000; 53rd WMA General Assembly, Washington 2002 (Note of Clarification on paragraph 29 added); 55th WMA General Assembly, Tokyo 2004 (Note of Clarification on Paragraph 30 added); 59th WMA General Assembly, Seoul, October 2008.

*Schloendorff v Society of N.Y Hospital*⁶⁹ involved situations in which there was no consent at all, or the consent given by the patient was exceeded, or a different procedure other than the one to which consent was given was carried out.⁷⁰

It was not until 1957 that the term “informed consent” was used to describe the duty of physicians to their patients. In the Californian case of *Salgo v Leland Stanford Jr University Board of Trustees*,⁷¹ an apparently competently performed aortography caused permanent paralysis of the plaintiff’s lower extremities. Part of the plaintiff’s testimony was that he was not informed that anything in the nature of an aortography was to be performed. This was contradicted by the defense. However, the defense admitted that the details of the procedure and its possible dangers were not explained to the plaintiff.

In ordering a retrial, the court noted that the jury was given a broad instruction that the physician has a duty to disclose all the facts which affect the patient’s right and interests and also the surgical risks, if any. The court held that a physician violates his or her duty to his or her patient and subjects himself or herself to liability if he or she withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed medical treatment. The court further held that a physician may not minimize the known dangers of a medical procedure to induce consent, though the physician must place the welfare of his or her patient above all else.⁷²

The court also held that requiring physicians to disclose all facts to the patient and also, to promote the welfare of the patient, puts the physician in a position in which he or she has to choose between two options: first, to explain to the patient every risk attendant

⁶⁹ *Schloendorff, supra* note 25.

⁷⁰ See for example *Mohr v Williams*, 95 Minn 261, 265; 104 NW 12 (1905); *Meek v City of Loveland*, 85 Colo 346 276 p 30 (1929).

⁷¹ *Salgo v Leland Stanford Jr University Board of Trustees*, 154 Cal App 2d 560 (1957).

⁷² *Ibid* at 578-579.

upon any surgical procedure, no matter how remote and, consequently, to unduly alarm an already apprehensive patient, or increase the risks by reason of the physiological apprehension; second, to recognize that each patient presents a separate problem, and that mental and emotional health is equally important, so that in discussing the risks, the physician may exercise discretion on what to disclose. The court held that a physician has “a certain amount of *discretion* [which] must be employed consistent with the *full disclosure* of facts necessary to an informed consent.”⁷³

The question is how to reconcile “discretion” to withhold information with “full disclosure.” Insight was provided in the latter case of *Natanson v Kline*.⁷⁴ In this case, the patient consented to the treatment that was carried out. Subsequently, in a malpractice suit, she alleged that her consent was not informed because the physician failed to disclose the risks of treatment. The court reviewed several cases⁷⁵ and opinions to conclude that a physician is not obligated to provide full disclosure of facts, diagnoses, alternatives or risks of treatment. The court noted that full disclosure may so alarm a patient that it would, in fact, constitute bad medical practice.⁷⁶ Except where there is reason to withhold information on therapeutic grounds, the court held that a physician should make substantial disclosure to the patient or risk liability in tort.⁷⁷

By this decision, the court recognized that physicians may exercise discretion on what to disclose, and even to withhold information entirely if disclosure would affect the health of the patient. However, provided a patient is of sound mind, American culture, which demands thorough-going self-determination, requires that the patient should make the

⁷³ *Ibid* at 578 (emphasis supplied).

⁷⁴ *Natanson v Kline*, 186 Kan 393, 350 P 2d 1093 (1960), opinion on denial of motion for rehearing 187 Kan 186 354 P 2d 670 (1960) [*Natanson*].

⁷⁵ Including the Supreme Court of Minnesota case of *Bang v Charles T Miller Hospital*, 251 Minn 427 88 NW 2d 186 (1958); and the Canadian case of *Kenny v Lockwood* (1932), 1 DLR 507.

⁷⁶ *Natanson*, *supra* note 74 at 406.

⁷⁷ *Ibid*.

decision, and the physician is not permitted to substitute his or her judgment for that of the patient by any form of artifice or deception.⁷⁸ Just as in *Salgo*, the court held that the duty of the physician is limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances. Most significantly, the court held that:

so long as the disclosure is sufficient to assure an informed consent, the physician's choice of plausible courses should not be called into question if it appears, all circumstances considered, that the physician was motivated only by the patient's best therapeutic interests and he proceeded as competent medical men would have done in a similar situation.⁷⁹

In other words, whether disclosure is sufficient, is to be determined by how informed it makes the patient. This will include how much of it the patient understands. Stretching this further, it would mean, as further discussed in Chapter Three, that what standard of disclosure to adopt is unnecessary, for any standard adopted must ensure that the patient's consent is informed. If this meaning is validly read into the court's decision, then it would follow that the true reason for requiring informed consent will be understood as not to merely recite risks, but to educate patients so that they can decide whether or not to consent to the treatment.

Evident from all of the foregoing is that informed consent serves a particular purpose: to protect patients' right of self-determination. This right is asserted against the traditional professional obligation of physicians to pursue and protect the welfare of their patients. A brief discussion of autonomy and beneficence, values implicated by informed consent, are presented next.

⁷⁸ *Ibid* at 406-407.

⁷⁹ *Ibid* at 409-10.

2.4 Ethical Values Implicated by Informed Consent

Underlying the requirement of informed consent are certain moral values deemed important and deserving of protection. Under the Nuremberg Code, the free agency of the research subject was held important. Thus, informed consent was required as an assurance that research participants do not act out of fraud, duress, deceit, misrepresentation, or any other constraining factor. In clinical medicine, and even in research, informed consent is justified on the basis of the right of self-determination, generally referred to as patient autonomy. This right is asserted against the paternalism tradition in medical research and practice. The goal is that physicians should no longer treat patients paternalistically, except in very limited instances where patients lack capacity, such as in emergencies. As well, control of treatment decisions should rest on the patient, not the physician.⁸⁰ Evident in the foregoing are two central ethical values: promotion of patient well-being, and respect for self-determination.

2.4.1 *Promoting Patient Well-Being: the Principle of Beneficence*

A primary reason why patients seek medical treatment is to improve their health and advance their wellbeing. As such, a physician is obliged to take positive steps to promote patient health and wellbeing. In ordinary parlance, beneficence is synonymous with altruism, blessing, enhancement, love, betterment, improvement, kindness and charity. It includes all actions which are intended to benefit another person. Central to bioethics are the obligations to confer benefits, remove or reduce possible harm and to weigh and balance possible good against potential harm.⁸¹ Often times, these obligations are not implemented by a single means. For example, a fractured limb may be repaired in several ways other than by surgery; and different drugs and injections other than the ones given may be used to treat the same health problem. Expectedly,

⁸⁰ See Robert M Veatch, "Autonomy's Temporary Triumph" (1984) 14 The Hastings Center Report 38.

⁸¹ Beauchamp & Childress, *supra* note 5 at 260.

any positive steps taken would improve the health of the patient. However, whether the particular steps taken are the best means of improving the patient's health is a different matter. A decision about the course of treatment to undertake necessarily involves value judgment and preferences. A physician exercising this judgment is usually guided by the need to promote the patient's welfare.

In the modern restatement of the Hippocrates Oath,⁸² physicians recognize that the art of medicine requires warmth, sympathy and understanding which sometimes outweigh the knife and drugs. Physicians also recognize that a patient is more than a chart or a cancerous growth, and that they must see their responsibilities as being towards a sick person whose illness may affect his or her family and economic stability, and to prevent disease whenever they can. These are all geared towards benefiting the patient and, where they form the moral basis of treatment decisions, it is reasonable to conclude that the patient's best interest will be protected.

Often times, the decision made accords with the preference of the patient, or where the patient does not have an original preference, the patient is, nonetheless, satisfied with the outcome. But there are instances where the physician's professional opinion may conflict with the desires of the patient. This is where the challenge lies. Should the physician be allowed to do what, in his or her opinion, is in the best interests of the patient, given his or her training and skill in matters of the temporal body? Or should the patient's preference prevail, given that the temporal body belongs to him or her and it is him or her, not the physician, who will live with the outcome of the treatment?

One suggestion is that where the decision involves medical science, the physician, with his or her training and expertise, is in a better position to decide what the best approach would be. On the other hand, a non-medical decision is properly left for the patient, as it

⁸² Penned in 1964 by Dr Louis Lasagna, former principal of the Sackler School of Graduate Biomedical Sciences and Academic Dean of the school of Medicine at Tufts University.

does not require any special skill.⁸³ An example would be a decision whether to undergo surgery for a slipped disc, or take medications and have bed rest. Such a decision is not totally dependent on medical knowledge, but depends also on the preferences of the patient. Deferring to this preference does not detract from the physician's obligation to promote the health and wellbeing of the patient. However, it is not clear in what sense a decision can be said to involve medical science for it to be made by the physician. It ought to be that where there are several viable options, the physician should present them to the patient who would decide on the option he or she prefers.

Recognizing that patients may prefer one treatment and not the other, or may prefer no treatment at all, and that they are competent to make this choice, requires that, in the promotion of a patient's health, physicians should necessarily accommodate these preferences under a broad definition of health which includes emotional, psychological and social health. Since there is no definite best approach to a medical problem and patients decide on a treatment option for subjective reasons, the physician's obligation to promote patient health and wellbeing should, to an extent, be dependent on the patient's preferences. However, the options provided are those which, to a higher or lesser degree, will protect patient health and wellbeing.

Another reason to defer to the patient's preference is because it is his or her preference and he or she has the right to it. This is referred to as the right to personal autonomy. This right is the other, arguably the main, ethical value implicated in the concept of informed consent.

2.4.2 *Respecting Self-Determination: The Principle of Autonomy*

The term "autonomy," in its original formulation, had more to do with the politics of self-government dating back to the European Enlightenment, rather than to healthcare

⁸³President's Commission Report, *supra* note 22 at 42.

or the individual.⁸⁴ Since the Enlightenment, the principle of autonomy came to be associated both with states and individuals, and it proceeded to form the legal and philosophical core of much of the discussion on bioethics.⁸⁵ The importance of individual autonomy is central to bioethical discussions about end-of-life decisions, reproductive technology, and sale of body parts or tissues. But in this thesis, it is explored in the limited sense in regard to making decisions about treatment.

In the book, *The Theory and Practice of Autonomy*, Gerald Dworkin notes that there are many and varied meanings of the concept of autonomy, but that the only unifying factor among them is that it is “a feature of persons and that it is a desirable quality to have.”⁸⁶ In this thesis, persons are taken to be emotional, embodied and interconnected, but still retain a distinct identity that differentiates them from others. Self-determination reflects an individual’s exercise of the capacity to form, revise and pursue plans for his or her life.⁸⁷ As already indicated above, patients have preferences about medical treatment which accords with their subjective values, shaped by their relationships, and which a physician, in the promotion of the health and wellbeing of the patient, is required to respect and accommodate.

The need to respect a patient’s preference flows from the instrumental and intrinsic importance of self-determination.⁸⁸ Instrumentally, the outcome that will best promote a patient’s well-being is the one determined by him or her; intrinsically, self-

⁸⁴ Jacquineau Azetsop & Stuart Rennie, “Principlism, Medical Individualism, and Health Promotion in Resource-Poor Countries: Can autonomy-Based Bioethics Promote Social Justice and Population Health?” (2010) 5:1 Philosophy, Ethics, and Humanities in Medicine 1.

⁸⁵ Donnelly, *supra* note 1 at 10.

⁸⁶ Dworkin, *Theory and Practice of Autonomy*, *supra* note 13 at 6.

⁸⁷ Gerald Dworkin, “Autonomy and Informed Consent” (1982) in President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research, *Making Health Care Decisions: The Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship* Volume Three: Appendices Studies on the Foundations of Informed Consent (Washington DC: US Government Printing Office, 1982) 63.

⁸⁸ President’s Commission Report, *supra* note 22 at 44-45.

determination affects the moral worth of an individual and is thus important in its own right.

The impact of the individual's social environment on his or her values, and, consequently, his or her choices, deserves notice. This is due to the fact that social environments either foster or thwart the development and exercise of autonomous potential by an individual.⁸⁹ An individual may display attributes of himself or herself which are socially reinforced, thus, his or her originality may, from the outset, be undermined by convention, and by the consequences of socialization. This potentially makes autonomy a matter of degree: (i) the extent an individual is able to act according to his or her desires; (ii) the extent the desires are influenced by his or her relationships; and, (iii) the extent his or her exercise of autonomy is "episodic" or "programmatic", in the sense of a one-off specific decision, or a long term life shaping decision, such as deciding to be a mother.⁹⁰ Where the consequences of socialization or social structure impair full autonomy, that socialization may be described as oppressive.⁹¹

On the other hand, where an individual's professed desires are fashioned by his or her subordinated status, are those desires deserving of respect as autonomous decisions? If not, might we not be at risk of infringing on the self-determining rights of the individual? Yet, if we respect those desires, will we be encouraging such subordination? Diana Meyers suggests that all desires need not be treated equally. According to her, only autonomous desires, that is, desires developed through self-discovery, compared to desires which are formed from uncritically accepted norms, deserve respect.⁹²

The problem with Meyers' suggestion is that it may further erode the autonomous capacity of the individual. In essence, her suggestion tells the individual that "because

⁸⁹ Mackenzie & Stoljar, *supra* note 16 at 17.

⁹⁰ See generally Diana Tietjens Meyers, *Self, Society, and Personal Choice* (New York: Columbia University Press, 1989).

⁹¹ Mackenzie & Stoljar, *supra* note 16 at 18.

⁹² See generally Meyers, *supra* note 90 at xi.

you are acting or deciding based on your inferior position, your decision cannot be respected.” For Susan Wolf, an autonomous person is one who has the capacity to identify and distinguish right from wrong.⁹³ She argues that, because oppressive socialization interferes with this capacity, persons subject to it are not autonomous. According to her, such socialization may lead to internalization of norms which, once internalized, cloud an individual’s ability to objectively evaluate, criticize or judge those norms. However, just as with Meyers, the question remains whether decisions made by persons who have internalized certain oppressive norms are to be respected, nonetheless. It is doubtful that a clear answer exists, one which does not raise more questions.

As mentioned earlier, often times, where a treatment decision is left to the physician, the decision made accords with the patient’s values or satisfies his or her preferences, however formed. In such instances, it is arguable that respect for self-determination and beneficence exist in harmony. The beneficence-driven physician does not injure the autonomy-seeking patient because, by the treatment decision made, the absence of self-determination did not interfere with the promotion of the well-being of the patient. It is argued that unless the patient requested the option taken, he or she would not have been shown proper respect nor protected from arbitrary, though well meaning, control by others.⁹⁴

A counter argument is that since the decision made by the physician accords with what the patient would have chosen for himself or herself, he or she cannot, in the real sense of the word, be said to have been disrespected. Following this argument, it would be different where the physician purports to know what is in the best interest of the patient, which does not correspond with what the patient thinks is in his or her best interest. In such a situation, proceeding with the physician’s idea of what is in the patient’s best interest will be disrespectful of the patient’s autonomy. But even this

⁹³ Mackenzie & Stoljar, *supra* note 16 at 19.

⁹⁴ President’s Commission Report, *supra* note 22 at 45.

argument potentially denies a patient's autonomous capabilities on the grounds that the physician has made an accurate assessment. Thus, it is essential that the patient be allowed to decide what is in his or her interest, even where the physician is able to accurately assess what the best interest is.

Self-determination operates as a sword.⁹⁵ In this sense, the concept of agency describes the ability or the right of a person to cause events as a subject, rather than be the object of other people's causative actions. Here, individuals are seen as possessing values which mark them out as distinct and unique from other persons. Consequently, decision making, especially in healthcare, where the patient bears the consequences of whatever treatment option is pursued, should properly reflect the purposes and values of the patient rather than be externally determined. Such a decision must not only be expressed by way of a choice among options, but it must also be educated in terms of the implications of any choice, including the choice of refusing treatment. According to the President's Commission:

If people have been able to form their own values and goals, are free from manipulation, and are aware of information relevant to the decision at hand, the final aspect of self-determination is simply the awareness that the choice is their own to make. Although the reasons for a choice cannot always be defined, decisions are still autonomous if they reflect someone's own purposes rather than external causes unrelated to the person's "self." Consequently, the Commission's concept of health care decision making includes informing patients of alternative courses of treatment and of the reasoning behind all recommendations. Self-determination involves more than choice; it also requires knowledge.⁹⁶

The importance of knowledge to self-determination is evident in treatment refusals where studies have shown that a contributing factor to treatment refusal is insufficiency

⁹⁵ See generally Isaiah Berlin, "Two Concepts of Liberty" in *Four Essays on Liberty* (Oxford, Clarendon Press, 1969) at 118-138.

⁹⁶ President's Commission Report, *supra* note 22 at 47.

or lack of understanding of information which in turn compromises self-determination.⁹⁷ Facilitating and letting a person decide for himself or herself, and to advance his or her own values free from external influences⁹⁸ is, arguably, the greatest respect that can be paid to his or her individuality and, consequently, his or her autonomy.

Understandably, there are healthcare measures that cannot be chosen. Examples include public health measures such as food safety standards or air quality levels which an individual does not have powers to choose to comply with or not.⁹⁹ In some instances, choice may be overridden where it is in the interest of public health. An example is where a person is suffering from a communicable disease such as AIDS, hepatitis, meningitis, tuberculosis, and syphilis.¹⁰⁰ In such a case, the person must, pursuant to any existing public health legislation, submit to treatment.¹⁰¹ Choice may also be impossible in some cases, notably in emergencies, cases of severe mental impairment or extreme illness.¹⁰² The foregoing demonstrates that the right to self-

⁹⁷ See Paul S Appelbaum & Loren H Roth, "Treatment Refusal in Medical Hospitals" in President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research, *Making Health Care Decisions: The Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship* Volume Two: Appendices Studies on the Foundations of Informed Consent (Washington DC: US Government Printing Office, 1982).

⁹⁸ Not including factors or relationships which contribute in shaping the individual's sense of himself or herself.

⁹⁹ See generally, Manson & O'Neill, *supra* note 52 at 19; Onora O'Neill, "Informed Consent and Public Health" (2004) 359 *Philosophical Transactions: Biological Sciences* 1133.

¹⁰⁰ See *Health Act*, RSBC 1979 c 161 s 70; *Veneral Disease Act*, RSBC 1979, c 422 s 3; *Public Health Act*, RSM 1987 c P210, s 12(c); *Veneral Disease Act*, RSNB 1973, c V-2, ss 3,4(1); *Communicable Diseases Act*, RSN 1990, c C-26, s 15; *Health Act*, RSNS 1989, c 195 ss 76(1), 93. Cf Julie Hamblin & Margaret A Somerville, "Surveillance and Reporting of HIV Infection and AIDS in Canada: Ethics and Law" (1991) 41 *UTLJ* 224 (for a critique of mandatory testing and treatment of HIV and AIDS patients).

¹⁰¹ See for example, *Public Health Act*, RSA 2000, c P-37, s 20; *Public Health Act*, SBC 2008, c 28, ss 15-17.

¹⁰² See generally, Ellen I Picard & Gerald B Robertson, *Legal Liability of Doctors and Hospitals* 4th ed (Canada: Carswell, 2007) at 56-61.

determination is not absolute, and external influences may not always be denied.

2.5 Conclusion

The doctrine of informed consent plays a central role in modern biomedicine. It protects patient's right to physical inviolability. It also respects patients' right to self-determination. Common law ensures that the interest of patients in their physical inviolability is preserved, by imposing liability in damages on a physician who violates this right. Patients are entitled to give or withhold consent to treatment, and to receive relevant information about the treatment from physicians, in order to make an informed decision about whether to proceed with the proposed treatment, or any treatment at all. It may not be justifiable to deny a patient the right to be self-determining simply because of the oppressive effects of socialization. But care needs to be taken in order not to foster an environment where such oppressive socialization thrives. Thus, although physicians have a professional obligation to promote the welfare of the patient, and are well positioned to do this, it is important that patients are empowered to be able to veto the medical treatment that they are offered. This will guard against a misuse of professional power, protect patients from being taken advantage of by physicians and respect their right to be self-determining.

As the foregoing show, whether in a research setting or clinical setting, the doctrine of informed consent is premised on the presence of several interlocking requirements which must be met. Chapter Three examines these elements in detail, both conceptually and through their articulation in the jurisprudence of a selected number of common law jurisdictions.

Chapter Three

Informed Consent: Constitutive Elements

3.0 Introduction

From the Nuremberg Code, the Helsinki Declaration, judicial interpretations and scholarly discussions of informed consent, the perception is that informed consent is an autonomous decision made by a voluntarily acting patient who has the capacity and knows the implications of that decision. Implicit within the concept are the twin elements of “information” given to a patient with capacity to understand it, and “consent” proceeding voluntarily from the patient pursuant to understanding that information. The information component refers to both disclosure of information and understanding of the information. The consent component encompasses the voluntary decision which may be an authorization or a refusal of a medical treatment. Whether a particular consent satisfies the requirements of informed consent is analyzable in terms of competence, disclosure, understanding and voluntariness. A proper definition of informed consent to medical treatment must account for the presence and interconnectedness of these elements. Therefore, informed consent is a voluntary decision made by a competent patient following disclosure of information and an understanding of the information disclosed.

Implicit within the above definition, are the elements of informed consent. This chapter discusses these elements in detail. The chapter begins with competence as an element of informed consent. It examines the various notions of competence as understanding, consistency, rationality and appreciation. It finds that competence encompasses the various notions and suggests that it should be functionally assessed. This assessment may be done using either standards or, preferably, a sliding scale. A sliding scale assesses competence based on the significance of the decision to be made. However, it

is not without limitations. The competence of minors to consent to treatment is isolated and explored across countries like the United States, Canada, the United Kingdom, South Africa and Australia. In all these countries, it was found, first, minors are not, by reason of age alone, incompetent. Second, depending on their level of maturity, minors may consent to treatment. Third, minors may not refuse necessary treatment, except where such refusal is consistent with their best interest.

Voluntariness as an element of informed consent is discussed primarily in terms of undue influence. However, other constraints on voluntariness like fraud, misrepresentation and duress are briefly highlighted. Also discussed is the effect of oppression on a patient's exercise of autonomy.

The next section discusses disclosure as an element of informed consent. It presents arguments which justify disclosure as therapeutic. It examines the two standards by which materiality of information for disclosure is measured. It notes that a component of disclosure is the duty to ensure that the patient understands. Following from this, it questions the point at which consent of a patient is informed: whether at the informational level or at the understanding level. It suggests that consent should be informed when the patient understands the information he or she has been given. Accordingly, it suggests "informed" as an ideal standard of disclosure. However, it notes that ensuring understanding may be challenging and suggests ways understanding may be both enhanced and ascertained.

Lastly, causation as an evidential element of informed consent negligence action is explored. The challenge posed to plaintiffs by the test for causation is highlighted. It is suggested that such challenges may be met by making choice a legally protectable interest and making breach of duty to disclose actionable on its own without a need to prove injury.

3.1 Competence or Capacity as an Element of Informed Consent¹⁰³

A preliminary matter

It is a general legal presumption that every adult individual is competent to give authorization for treatment, except where legislation or the courts have decided otherwise.¹⁰⁴ Debates about competence in medical treatment focus on whether a person is, psychologically or legally, able to understand the information relevant to making a decision about the treatment, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.¹⁰⁵ Competence distinguishes patients whose decisions would be accepted, from those whose decisions need not be solicited or, where given, need not be accepted; it sets apart those who can and should decide their own treatment, from those whose treatment decisions should be overridden or made by a surrogate.¹⁰⁶ In other words, competence determines whether autonomy or paternalism¹⁰⁷ would prevail. A finding of incompetence justifies

¹⁰³ Throughout this thesis, the words ‘competence’ and ‘capacity’ are used in the same sense.

¹⁰⁴ *AC v Manitoba (Director of Child and Family Services)*, [2009] SCJ No 30, 2009 SCC 30 [*AC v Manitoba*]; Lorne E Rozovsky, *The Canadian Law of Consent to Treatment* 2nd ed (Toronto: Butterworths, 1997) at 3; Lorne E Rozovsky, *Consent to Treatment: A Practical Guide* 2nd ed (Toronto: Little, Brown and Company, 1990) at 17; *Health Care Consent Act*, SO 1996, [being Schedule A to the *Advocacy, Consent and Substitute Decisions Statute Law Amendment Act*, SO 1996, c 2; proclaimed in force March 29, 1996] s 4(2).

¹⁰⁵ See *Health Care Consent Act*, SO 1996, [being Schedule A to the *Advocacy, Consent and Substitute Decisions Statute Law Amendment Act*, SO 1996, c 2; proclaimed in force March 29, 1996] s 4 (1); Beauchamp & Childress, *supra* note 5 at 132.

¹⁰⁶ Beauchamp & Childress, *ibid* at 133.

¹⁰⁷ It is arguable that where a patient is incompetent, having a substitute decision maker decide on his or her behalf is respectful of his or her autonomy. But, unless the patient had, while competent, instructed the substitute decision maker to act on his or her behalf, it is expected that the substitute decision maker will be acting in what he or she perceives to be the patient’s best interest. This is paternalism. Paternalism as used in this thesis, refers to decision making, by persons other than the patient, in the interest

paternalism. Where incompetence is caused by pain, anxiety or other reversible factor, the primary objective of the physician should be to restore or enhance competence prior to decision making.

3.1.1 *Defining Competence*

It is difficult to define with certainty the abilities one must possess to be adjudged competent and what distinguishes a competent patient from an incompetent one. Is a competent patient one whose decisions accord with a notion of reasonability, or one whose decision does not conflict with the opinion of the physician? As noted by Beauchamp and Childress, it is difficult to draw a line between competence and incompetence which is not arbitrary.¹⁰⁸

According to John Stuart Mill, a competent person is of full age and has an ordinary amount of understanding.¹⁰⁹ For Ronald Dworkin, the autonomous individual is one who has “the ability to act out of genuine preference or character or conviction or a sense of self.”¹¹⁰ John Rawls equates capacity with the ability to act freely and rationally.¹¹¹ A comprehensive definition of competence would encompass all of the foregoing views. Accordingly, a patient lacks competence if he or she is not able to appreciate his or her

of the patient. For a general discussion of paternalism and its classifications, see Gerald Dworkin, “Paternalism” The Stanford Encyclopedia of Philosophy (summer 2010 Edition), Edward N Zalta (ed) online:

<http://plato.stanford.edu/archives/sum2010/entries/paternalism/>.

¹⁰⁸ Beauchamp & Childress, *supra* note 5 at 133.

¹⁰⁹ Mill, *supra* note 4 at 84. In his wayfarer example, Mill argues that having stopped the wayfarer to warn him of a dangerous bridge ahead, nothing more can justifiably be done if the wayfarer, despite the warning, continues on his way unless the wayfarer is “a child, or delirious, or in some state of excitement or absorption incompatible with the full use of the reflecting faculty.” *Ibid* at 97.

¹¹⁰ Ronald Dworkin, *Life’s Dominion: An Argument about Abortion, Euthanasia, and Individual Freedom* (New York: Alfred A Knopf, 1993) at 225.

¹¹¹ John Rawls, *Theory of Justice* (Cambridge, MA: Harvard University Press, 1971) at 516.

medical condition, understand relevant information about its treatment, or unable to use this information as part of the decision-making process.

3.1.1.1 Competence as Ability to Understand and Appreciate the Nature and Consequences of Treatment

Competence assesses the ability of patients to understand and appreciate the nature and consequences of treatment rather than actual understanding and appreciation.¹¹² For a person to be capable of understanding the information relevant to his or her treatment decision, he or she must be capable of intellectually processing the information as it applies to his or her treatment, including its potential benefits and risks.¹¹³ Actual understanding and appreciation demonstrates the presence of ability to understand and appreciate.¹¹⁴ This does not mean that the opposite is true. While lack of understanding may be an indication of incompetence, it is not determinative.¹¹⁵ Lack of understanding may result from poor communication rather than from any defect in the patient's capacity. In other words, a patient may be competent and yet not understand the information given.¹¹⁶ However, once a patient acknowledges that he or she has a set of symptoms for which certain treatment is proposed, and understands the implication of the treatment and the consequences of no treatment, the patient is competent. This is irrespective of whether he or she agrees with the name given to the symptoms, the cause of the symptoms or the recommended treatment.¹¹⁷

¹¹² See *Starson v Swayze*, [2003] 1 SCR 722, (2003), 225 DLR (4th) 385 (SCC) [*Starson*].

¹¹³ *Ibid* at para 80.

¹¹⁴ Picard & Robertson, *supra* note 102 at 70.

¹¹⁵ *Ibid*.

¹¹⁶ Where a patient does not understand the information given, the consent that is obtained may not be valid being that it is not sufficiently informed. Consent is informed at the point where a patient understands the information relevant to, and implication of, treatment.

¹¹⁷ See *Starson*, *supra* note 112 at para 79-80.

In *Starson v Swayze*,¹¹⁸ the majority of the Supreme Court of Canada held that a patient need not describe his or her medical condition as an illness, or describe it in any negative terms. Provided he or she acknowledges that he or she has a medical condition and is possibly affected by it, according to the majority judgment, he or she is competent. On the other hand, where the health condition makes the patient unable to recognize that he or she is affected by its manifestations, he or she is incompetent.¹¹⁹

The implication of the majority decision in *Starson v Swayze* is that, provided the patient has a cognitive understanding of, for example, the nature and the treatment for bipolar disorder, acknowledges that he or she has the symptoms that are associated with it, he or she would be capable. The physician does not have to satisfy himself or herself that the patient applied the information to himself or herself. Consequently, such a patient may deny that he or she has bipolar disorder but accept that he or she experiences extreme, intense and long lasting swings in mood, energy, thinking and behavior, from a maniacal high, to a depressive low, which interferes with his or her ability to function. If he or she understands the nature and implication of the treatment proposed for bipolar disorder, he or she is competent.

3.1.1.2 Competence as Consistency and Authenticity

Ronald Dworkin defines competence as the ability to be consistent or authentic with one's sense of self.¹²⁰ In the context of patients with dementia, Dworkin argues that

If [a patient's] choices and demands, no matter how firmly expressed, systematically or randomly contradict one another, reflecting no coherent sense of self and no discernible even short-term aims, then he has presumably lost that capacity that it is the point of autonomy to protect.¹²¹

¹¹⁸ *Ibid.*

¹¹⁹ *Ibid* at para 79.

¹²⁰ Dworkin, *supra* note 110 at 224.

¹²¹ *Ibid.*

Dworkin makes a distinction between an individual's critical and experiential interests. In other words, he distinguishes between the interests that define the individual's life and ensures that his or her choices "keep faith with the way [he or she] ... wanted to live,"¹²² and current interests such as pleasure or pain. Although in general terms, consistency and authenticity are evidence that the person acting has capacity, Dworkin's argument does not imply that an individual must consistently adopt a particular value, even where the circumstances are different.¹²³ Rather, Dworkin, arguably, contemplates a systematic contradiction of choices or views without a discernible pattern or cause. Where this occurs, Dworkin views the patient as having lost the capacity that autonomy is meant to protect. Dworkin's emphasis on the individual's critical interests or life values¹²⁴ seem to suggest that where a patient makes a choice that appears consistent with his or her stable preferences, that choice will be respected. What happens where there is indication that, though consistent with his or life values, the patient failed to understand or retain the information received in order to make a reasoned decision. Whether consistent or not, in Canadian law, a patient is competent if he or she understands and appreciates the nature and implications of the decisions he or she is making.¹²⁵

3.1.1.3 Competence as Rationality

Contrary to John Rawl's argument that a competent patient is one who can act freely and rationally,¹²⁶ that a patient's decision conflicts with a notion of rationality is not, without more, evidence of incapacity. In the first instance, requiring persons to make

¹²² *Ibid* at 199.

¹²³ Compare with John A Robertson, "Autonomy's Dominion: Dworkin on Abortion and Euthanasia" (1994) 19:2 *Law & Social Inquiry* 457 at 478-81. According to Robertson, Dworkin's view "gives priority to past exercises of autonomy even when doing so conflicts with the incompetent person's current best interests" at 480-81. He notes further (at 481) that, based on a previous directive, Dworkin would refuse to give transfusion even if the person, in his demented state, requests it.

¹²⁴ See for example Dworkin, *supra* note 110 at 199-214.

¹²⁵ See *Starson*, *supra* note 112.

¹²⁶ Rawls, *supra* note 111 at 516.

rational or good decisions is inconsistent with John Mill's concept of liberty and with judicial authorities which allow individuals the right to be foolish.¹²⁷ Second, focusing on the apparent irrationality of a patient's decision to determine capacity, where the irrationality is seen as evidence of an unsound mind rather than as an assertion of will, undermines a patient's right of self-determination.¹²⁸ But this is only one way of looking at capacity and rationality.

Mary Donnelly suggests another way of looking at capacity and rationality which focuses on the process leading to the decision rather than on the decision itself.¹²⁹ On this view, capacity requires an ability to reason and reflect on one's choice and to rationally manipulate the information received in order to reach a decision.¹³⁰ However, focusing on the process of the decision making is not without its flaws. First, a person may reach an irrational conclusion through a rational thought process.¹³¹ According to Donnelly, an example of such situation would be where a person at risk refuses to be screened for a sexually transmitted infection, because he or she believes that if he or she does not know that he or she has it, he or she will not experience its symptoms.¹³² Second, a thought process may, arguably, be evaluated based on the decision that is made. Therefore, an irrational decision may be taken to mean an irrational thought process and evidence of incapacity.

¹²⁷ See for example *Malette*, *supra* 30 at 328 where Justice Robins held that "people must have the right to make choices that accord with their own values regardless of how unwise or foolish those choices may appear to others."

¹²⁸ Picard & Robertson, *supra* note 102 at 70.

¹²⁹ Donnelly, *supra* note 1 at 97.

¹³⁰ *Ibid.*

¹³¹ *Ibid.*

¹³² *Ibid.* Similarly, in *St George's Healthcare NHS Trust v S*, [1998] 3 WLR 936, the patient refused to undergo a caesarean section, notwithstanding the substantial risk posed to the foetus, because she believed that nature should be allowed to take its course.

3.1.1.4 Functional View of Competence: A Suggestion

Present in the various notions of competence as understanding and appreciation, consistency or authenticity, and rationality, is the idea that competence presupposes ability to accomplish a task, in this case, to make a decision about treatment.¹³³ The nature of the decision to be made also affects whether a person who is competent to make one decision retains the competence to make a different decision. This implies that competence to decide is specific, both to the individual and to the decision.¹³⁴ In other words, assessing a person's ability to make a decision is specific to the decision to be made; it is not generalized to other decisions. It is possible that a person who is adjudged to be incompetent to perform acts, such as managing his or her estate, getting married, or voting in an election, may, otherwise, be competent to make medical decisions,¹³⁵ or be able to make one medical decision and not another. In effect, functionality disallows a presumption of continuance which arises where a person found to be incompetent at one time, is presumed to remain incompetent at all times.¹³⁶

A person's competence may fluctuate as a result of illness or a generally competent patient may act incompetently in a particular situation. For example, a patient may accept a suggested treatment option even though it conflicts with what she really wants, either because she is awed by the physician or the hospital environment, or because she has a personality that is not assertive. A functional view of competence requires that the patient be assessed with respect to the particular decision that is to be

¹³³ DN Weisstub (Chairman), *Final Report of the Enquiry on Mental Competency* (Toronto: Ontario Ministry of Health, 1990) at 248-250; Beauchamp & Childress, *supra* note 5 at 134.

¹³⁴ *AC v Manitoba (Director of Child and Family Services)*, *supra* note 104; Brian F Hoffman, *supra* note 104 at 16; Picard & Robertson, *supra* note 102 at 71.

¹³⁵ See for example, *Khan v St Thomas Psychiatric Hospital* (1992), 87 DLR (4th) 289 (Ont CA), leave to appeal to SCC refused (1992), 93 DLR (4th) vii (note) (SCC).

¹³⁶ This presumption operated in England until it was rejected by the English Court of Appeal in *Masterman-Lister v Brutton & Co*, [2002] EWCA Civ 1889.

made. One way of carrying out this assessment is by the use of standards. Another way is by the use of a sliding scale. Each of these is explored in more detail below.

3.1.2 *Assessing Competence*

3.1.2.1 Determining Competence Using Standards

Debates about assessing competence based on cognitive ability turn on the standard to be used in measuring competence. Beside age as a standard, the schema of standards of competence runs through one requiring the least ability, to one requiring the most ability. The standards include

1. Inability to express or communicate a preference or choice
2. Inability to understand one's situation and its consequences
3. Inability to understand relevant information
4. Inability to give a reason
5. Inability to give a rational reason (although some reasons are given)
6. Inability to give a risk/benefit related reason (although some rational reason is given)
7. Inability to reach a reasonable decision

The above standards may be grouped into minimal, outcome and process standards.¹³⁷

3.1.2.1.1 Minimal Standard of Competence

This standard merely requires the simple ability of the patient to express a preference. It respects every choice of the patient and does not inquire into the reasoning behind the choice or disregards the defects or mistake in the reasoning process. It does not inquire whether the choice accords with the patient's own conception of his or her good, or

¹³⁷ See generally Allen E Buchanan & Dan W Brock, "Standards of Competence" reprinted in Thomas A Mappes & David DeGrazia, *Biomedical Ethics* 4th ed (New York: McGraw-Hill, 1996) 100 ["Standards of Competence"].

whether the choice will be harmful to the patient. This standard does not seek to protect patient well-being. According to Buchanan and Grock, it is insensitive to the way in which self-determination varies both with the nature of the decision to be made and with differences in people's capacity to choose according to their conception of their own good. The minimal standard has been described as weak,¹³⁸ and as not being a criterion of competent choice at all.¹³⁹

3.1.2.1.2 Outcome Standard of Competence

At the other end of the spectrum from the minimal standard is the standard that focuses on the content or outcome of the decision. This standard questions whether a patient has a reason for his or her decision; how rational the reason is; whether the reason is risk/benefit related; and, whether the decision reached is reasonable. It ultimately requires some rationality or reasonability in the decision made, in order for the person making it to be deemed competent. On this view, a failure of the decision to match what other reasonable or rational persons would choose implies that it is not a competent decision.¹⁴⁰ This standard maximally protects the well-being of the patient, but, it does not respect the self determination of the particular patient.

Central to self-determination is the interest of a patient in defining, refining and pursuing his or her own conception of the good life.¹⁴¹ Where the patient cannot or does not determine for himself or herself, he or she becomes subject to a paternal substitution of another's conception of what is in his or her best interest. Buchanan and Brock observe that the claim of an ideal standard which maximally protects a patient's

¹³⁸Beauchamp & Childress, *supra* note 5 at 137.

¹³⁹Buchanan & Brock, "Standards of Competence" *supra* note 137 at 101.

¹⁴⁰*Ibid.*

¹⁴¹*Ibid.*

best interest is only as strong as the basis on which the best interest of the patient is determined.¹⁴²

It is difficult to attempt to ascertain what may be in a patient's best interest. Even so, any determination of best interest which does not ultimately rest on the patient's own underlying values is "both problematic in theory and subject to intolerable abuse in practice."¹⁴³ Given that the decision envisaged is one about the appropriate treatment for a patient, a standard that measures competence by comparing the content of the patient's decision to some vague notion of reasonability may fail to appropriately protect the patient's best interest.

3.1.2.1.3 Process Standard of Competence

At the center of the spectrum, between the standard that defers strongly to self-determination and significantly less to patient welfare, and the standard that seeks to protect patient welfare over respect for self-determination, is a standard which balances both welfare and self-determination. This standard does not particularly focus on the decision that is made, or on the content of that decision. Rather, it focuses on the process that leads to the decision.¹⁴⁴ The process standard is guided by questions such as: how well must the patient understand and reason to be competent? How much can a patient's understanding be limited, or his or her reasoning defective, and still be compatible with competence? How certain must physicians be, that a patient has understood and reasoned, especially in marginal cases where the degree of uncertainty about competence is significant?¹⁴⁵ In answering these questions, Buchanan and Brock suggested a sliding scale technique which is analyzed shortly.

¹⁴² *Ibid.*

¹⁴³ *Ibid* at 102.

¹⁴⁴ *Ibid.*

¹⁴⁵ See generally Buchanan & Brock, "Standards of Competence" *supra* note 137.

The process standard is attractive. First, it respects and protects both patient self-determination and welfare without preferring one over the other. It does not abandon a patient to his or her decision, however harmful the decision may be. Thus, in principle, it respects a patient's choice in a way that does not cause him or her harm.¹⁴⁶ Its focus on the process leading to a decision makes it adaptable to the peculiarity of each patient. However, in practice, the process standard does not clarify how answers to the questions guiding the standard are to be determined.¹⁴⁷ The standard may also encourage paternalism in cases where the patient is deemed to lack sufficient understanding or reasoning. Accordingly, it appears that a sliding scale may present a better assessment tool.

3.1.2.2 Determining Competence Using the Sliding-Scale

The motive for determining competence is to protect patients from making decisions that may not be in their best interests.¹⁴⁸ Based on this, it is believed that competence should be closely linked to patients' levels of experience, maturity, responsibility, and welfare.¹⁴⁹ The sliding-scale strategy may be used to achieve this. The method of this strategy is that the higher the risks for a patient occasioned by medical intervention, the higher the competence required to accept, or refuse, it. Conversely, the lower or less substantial the risk that might occur, the lower the level of competence required to authorize it. For example, a medical intervention or non-intervention that has a risk of death would require a higher level of competence. On the other hand, if the risk involved is a rash or temporary dizziness, it would seem that a less exacting standard of competence will be required. Thus, with the sliding scale, the level of competence required increases with the degree of risks that is present in the medical intervention. It follows that an otherwise healthy patient might need only minimal competence to

¹⁴⁶ *Ibid* at 102.

¹⁴⁷ *Ibid*.

¹⁴⁸ Beauchamp & Childress, *supra* note 5 at 138.

¹⁴⁹ *Ibid*.

accept a low-risk life-saving procedure, but would require a higher level of competence to refuse the same procedure.¹⁵⁰

The attraction of the sliding scale seems obvious: it enables a balance to be maintained between respecting patients' autonomy and protecting their welfare. It does this by requiring a more stringent and thorough assessment of competence where the implication and consequences of a decision are grave.¹⁵¹ This is borne out of the need to ensure that the patient fully understands and appreciates the consequences of his or her decision. The opposite would be the case where the harm to the patient is minimal. But that is the positive side of the sliding-scale. The sliding scale strategy runs the risk of conflating the assessment of competence with the patient's competence.¹⁵² In other words, it suggests that a person's ability to decide his or her treatment depends on the consequences of his or her decision. This conflation is evident in the argument that because a patient is competent to consent to treatment, it does not mean that he or she is competent to refuse it.¹⁵³

The implication that caution must be exercised in allowing patients to assume a greater risk by requiring a higher standard of competence is disturbing. It implies that competence is variable, according to the consequences of the decision that is to be made. A patient is competent if he or she is able to understand the nature and implication of the decision he or she is making.¹⁵⁴ Assessing competence is, therefore, an examination of whether this ability is present. Where the consequences of the

¹⁵⁰ See Allen Buchanan & Dan Brock, "Deciding for Others" in Loretta Kopelman & John Moskop eds *Children and Health Care* (Boston: Kluwer Academic Publishers, 1989) 52 ["Deciding for Others"]; PDG Skegg, "Presuming Competence to Consent: Could Anything Be Sillier? (2011) 30:2 University of Queensland LJ 165.

¹⁵¹ See *AC v Manitoba (Director of Child and Family Services)*, *supra* note 104.

¹⁵² Beauchamp & Childress, *supra* note 5 at 139-40; See Mark R Wicclair, "Patient Decision-Making Capacity and Risk," (1991) 5 *Bioethics* 91.

¹⁵³ See Buchanan & Brock, "Deciding for Others" *supra* note 150 at 52-55.

¹⁵⁴ See *Starson v Swayze*, *supra* note 112.

decision are grave, it warrants a closer scrutiny of this ability.¹⁵⁵ In other words, the requirement for competence does not change. Rather, the ability of a patient to satisfy this requirement may be challenged where the consequences of the decision are severe.

Whether competence is assessed using standards or the sliding scale, including whether it is assessed at all, arguably depends, on the most part, on whether or not there is a conflict between the wishes of the patient and the physician's professional judgment. A UK study found that a significant proportion of patients who are admitted to hospital do not have decision-making capacity, yet the identification of this incapacity is not triggered unless the patient questions the doctor's decisions.¹⁵⁶ Consequently, it has been suggested that competence assessment must be made more routine.¹⁵⁷ This suggestion, if accepted, may undermine the *prima facie* presumption of the competence of adults. Rather than a routine assessment, it would be more functional if the physician is alert to any signs of incompetence, however veiled. For example, where a patient refuses a low risk treatment with a high therapeutic value which a reasonable person would accept, it should trigger a competence assessment. This indirectly requires the patient to be reasonable. The reality, however, is that an unreasonable decision only alerts the physician to the possibility of incompetence, for which he or she is to satisfy himself or herself that it is not the case. This point is further expanded by John Devereux and Malcolm Parker as follows:¹⁵⁸

If we value maximal freedom and efficiency, through the *prima facie* presumption of competency, we also must be alert to those conditions which should trigger an assessment of competency.... A refusal of treatment which has serious possible consequences should always be explored, in order to distinguish

¹⁵⁵ See *AC v Manitoba (Director of Child and Family Services)*, *supra* note 104.

¹⁵⁶ See Vanessa Raymont *et al*, "Prevalence of Mental Incapacity in Medical Inpatients and Associated Risk-Factors: Cross-sectional Study" (2004) 364 *Lancet* 1421.

¹⁵⁷ See for example, Joanna M Cain & Bernard J Hammes, "Ethics and Pain Management: Respecting Patient Wishes" (1994) 9:3 *Journal of Pain & Symptom Management* 160.

¹⁵⁸ Jon Devereux & Malcolm Parker, "Competency Issues for Young Persons and Older Persons" in Ian Freckelton & Kerry Petersen, eds, *Disputes & Dilemmas in Health Law* (Sydney: The Federation Press, 2006) 54 at 71.

between possible incompetence and a stable decision. Organic brain syndromes associated with trauma, drugs, alcohol, infection, dementia, and so on, should also be regarded as potentially extinguishing competency, as should mental states characterized by fear, anxiety, and depression, whether or not these are associated with mental illness. Nevertheless, it is crucial to accept that the mere presence of mental illness, or any of the other medical conditions mentioned do not, ipso facto, imply incompetence.

The above argument is wide enough to make competence assessment routine, except where the patient's illness is not serious enough to induce fear, anxiety or depression, or is not caused by trauma, drugs, alcohol or infection. The cases falling within the latter group would, it seems, constitute the exception rather than the rule, especially since illnesses are often caused by infection, or by trauma. Also, the consequences of illness include fear, anxiety and, sometimes, depression. In effect, the prima facie presumption of capacity is whittled down by Devereux and Parker's argument. However, this effect may be tolerated given that the legal consequences of an error in competence assessment are potentially severe. For example, if a physician carries out medical treatment relying on consent which proceeded from a person without competence, he or she may be liable for battery even if the procedure was competently performed.¹⁵⁹ Similarly, where a physician fails to carry out a medical procedure because he or she relied on a refusal of treatment from a person who was not competent, the physician could be liable in negligence for failing to treat the patient.¹⁶⁰

¹⁵⁹ The physician is excused from liability where he or she believes, on reasonable grounds, and in good faith, that the consent was valid. See *Health Care Consent Act*, SO 1996, c 2, Sch A s 29(1).

¹⁶⁰ However, if the physician believes, on reasonable grounds and in good faith that the refusal was valid, he or she may not be liable. See *Health Care Consent Act*, SO 1996, c 2, Sch A s 29(2) [being Schedule A to the *Advocacy, Consent and Substitute Decisions Statute Law Amendment Act*, SO 1996, c 2; proclaimed in force March 29, 1996]; *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996 (Supp) c 181, s 33(1); *Consent to Treatment and Health Care Directives Act*, RSPEI 1988, c C-17.2, s 18(1) [en. 1996, c 10; proclaimed in force July 1, 2000]; *Care Consent Act*, SY 2003, s 64 [being Schedule B to the *Decision Making, Support and Protection of Adults Act*, SY 2003, c 21; proclaimed in force May 2, 2005].

Thus, it is suggested that once there is suspicion of a pathological influence on the cognitive functioning of a patient, not necessarily because the decision has changed, competence assessment should be done. And, provided the patient demonstrates a capacity to understand and appreciate his or her condition, the nature and purpose of the proposed treatment and, to appreciate the consequences of treatment or no treatment, irrespective of the gravity of the consequences, he or she should be certified competent.¹⁶¹

The above suggestion avoids the sliding scale strategy and its implication that a patient may be competent to accept a treatment but incompetent to refuse it, though his or her understanding, values or beliefs have not changed. With the above suggestion, it is not so much about a change in the patient's understanding as it is about the need for the physician to be more certain about what the patient understands. However, it is acknowledged that the suggestion requires a relatively high expectation of knowledge on the part of the patient which may not be met because of impaired cognitive ability caused by the health condition, or as a result of anxiety or other illness-induced emotions.

3.1.2.3 Age as a Marker for Competence: A Case Apart

Apart from cognitive and psychological capacity, another operational criterion for determining competence is age. How countries like Canada, the United States, the United Kingdom, Australia and South Africa treat minors in respect to healthcare decision making is the focus of this part. The result of the comparison shows more commonality than differences in the treatment of minors.

3.1.2.3.1 Competence of Minors in Canada

The legal age of majority in Canada has progressively become irrelevant in determining when a minor is competent to make decisions about his or her medical treatment.

¹⁶¹ See *Starson v Swayze*, *supra* note 112 at para 80.

Common law on consent to treatment has evolved so that competence is measured based on the maturity of the minor rather than his or her chronological age.¹⁶² In other words, the determinant of competence in a minor is the extent to which his or her physical, mental, and emotional development allows for an understanding and appreciation of the nature and consequences of the proposed treatment, and the implications of refusing treatment.¹⁶³

The reliance on maturity to assess a minor's capacity to decide on his or her medical treatment has been codified by legislation in a number of provinces and the territories.¹⁶⁴ Only the Province of Quebec has a fixed age of 14 years, below which the consent of the parent or guardian of the minor, or of the court is required.¹⁶⁵ Refusal of treatment by a person who is 14 years or over may be overridden by a court or, in cases of emergency, by parents.¹⁶⁶

In *AC v Manitoba (Director of Child and Family Services)*, a 14 year old Jehovah's Witness minor who had an "advance medical directive" refusing blood products in any circumstances, suffered from gastrointestinal bleeding as a result of Crohn's disease and was assessed as being in imminent danger by her treating physician. A psychiatric assessment at the hospital found that she was alert, cooperative, bright, well spoken, and occasionally teary, and had no psychiatric illness. The assessment concluded that, although a minor, she understood why a transfusion is recommended as well as the consequences of refusing it. In other words, she was found to be a "mature minor."

¹⁶² See *AC v Manitoba (Director of Child and Family Services)*, *supra* note 104.

¹⁶³ *Ibid.*

¹⁶⁴ For example, in New Brunswick, the age of consent to treatment is 16. However, a younger child may provide effective consent if the child is capable of understanding the nature and consequences of a treatment and in the opinion of a physician, dentist or nurse, the treatment is in the best interest of the child with respect to his or her continued health and wellbeing. See *Medical Consent of Minors Act*, SNB 1976 c M-6.1, ss 2 and 3(1). See also *Walker v Region 2 Hospital Corp* (1994), 116 DLR (4th) 477 (NBCA).

¹⁶⁵ See *Civil Code of Quebec*, LRQ, c C-1991 art 14.

¹⁶⁶ *Civil Code of Quebec*, LRQ, c C-1991 art 16.

However, the Director of Child and Family Services apprehended her as a "child in need of protection" under Manitoba's *Child and Family Services Act*,¹⁶⁷ and obtained a treatment order enabling blood to be transfused in her. Following the transfusion, she recovered and, subsequently appealed the treatment order.

The majority judgment of the Supreme Court of Canada held that under the common law mature minor doctrine, children are entitled to a degree of decision making that reflects their evolving maturity.¹⁶⁸ The court acknowledged the continual struggle between respecting the autonomy of mature minors and carrying out the protective function of the state. The court held that the maturity of each minor must be taken into account for each particular medical treatment.¹⁶⁹ This results in a sliding scale of scrutiny; with the minor's view becoming more determinative with increasing maturity, and the level of scrutiny increasing with the complexity of the medical decision or the severity of its impact.

A summary of the implication of the majority judgment is that: (i) according to Manitoba's legislative framework, competent patients who are over the age of 16 may refuse medical treatment, regardless of the consequences of that decision; (ii) according to the framework, patients who are below the age of 16, but who are found to be "mature minors" may refuse non-essential medical treatment if it is in their best interests; (iii) a minor's best interests may, as he or she gets more mature, collapse into his or her desire and right to exercise autonomy, whatever may be the consequences of the exercise of that autonomy;¹⁷⁰ (v) where refusal of treatment carries serious consequences such as death or permanent disability, a more rigorous assessment of the

¹⁶⁷ *Child and Family Services Act, CCSM c C80, s 25(8) and (9)*. The decision in this case, is on the interpretation and constitutional validity of this legislation which permits a court to authorize treatment considered to be in the best interests of a child who is below the age of 16 years.

¹⁶⁸ *AC v Manitoba (Director of Child and Family Services)*, *supra* note 104 at para 46.

¹⁶⁹ *Ibid* at para 90 and 94.

¹⁷⁰ *Ibid* at para 87.

minor's maturity will be required;¹⁷¹ (vi) where the medical treatment is necessary to preserve life, it is likely that the court, exercising its *parens patriae* jurisdiction, will authorize treatment despite the contrary wishes of the mature minor; and (vii) in all cases, determining the minor's best interest must take into account the minor's expressed wish, with the weight given to such wish increasing with the minor's maturity. Since the psychiatric assessment in *AC v Manitoba (Director of Child and Family Services)* showed that the minor was mature enough to understand the nature of treatment and the implication of no treatment, it is challenging to appreciate the reason why treatment was still imposed on her, and why her decision was not determinative. According to Binnie J in his dissenting judgment:

[t]he state's interest in ensuring judicial control over the medical treatment of "immature" minors ceases to exist where a "mature" minor under 16 *demonstrates* the lack of need for any such overriding state control. In such cases, the legitimate object and basis of state intervention in the life of the young person has, by reason of the judge's finding of maturity, disappeared. Whether judges, doctors and hospital authorities agree or disagree with [the child's] objection, the decision belongs to her, as the *Charter* is not just about the freedom to make the wise and correct choice; it also gives her the individual autonomy and the religious freedom to refuse forced medical treatment, even where her life or death hangs in the balance, regardless of what the judge thinks is in her best interest. The state would be justified in taking the decision away from [the child] if there was any doubt about her capacity, as in a situation of urgency, or whether she was acting under the influence of her parents (who are Jehovah's Witnesses). However, these matters were looked into by three psychiatrists at the Winnipeg hospital where the blood transfusion was to be administered, and the psychiatrists concluded, and the applications judge accepted, that [the child] - though 14 months short of reaching 16 years of age - was nevertheless at the [material] time an individual "with the capacity to give or refuse consent to her own medical care."¹⁷²

Binnie J further contended that the position at common law is that proof of capacity entitles the "mature minor" to exercise personal autonomy in making medical treatment decisions free of parental or judicial control. He acknowledged the difficulty of persuading a judge that a young person who refuses potentially life-saving medical

¹⁷¹ *Ibid* at para 95.

¹⁷² *Ibid* at para 8 (Binnie J dissenting).

treatment is nonetheless competent, but noted that the Charter requires such an opportunity to be given.¹⁷³ Binnie J's reasoning accords with the discussion on competence and how it may be assessed. A minor who understands and appreciates the decision to be made including the consequences of refusing treatment is competent. It should not matter what the consequences are of refusing treatment.

The implication of the decision in *AC v Manitoba (Director of Child and Family Services)* is, arguably, similar to the position in other common law jurisdictions. As will be seen shortly, while competence in minors is functionally assessed, courts in other jurisdictions have generally been reluctant to accept the exercise of the right to refuse treatment. The right accorded to minors who have sufficient maturity first arose in the United Kingdom. The position of minors in the United Kingdom is discussed next.

3.1.2.3.2 Competence of Minors in the United Kingdom

In the United Kingdom, minors aged 16 years or over have a statutory right to consent to medical treatment without parental consent.¹⁷⁴ However, the rights of those under 16 years of age are governed by the seminal case of *Gillick v West Norfolk and Wisbech Area Health Authority*.¹⁷⁵ The central issue in this case was whether a doctor can ever, in any circumstances, lawfully give contraceptive advice or treatment to a girl under the age of 16 without parental consent. The Department of Health and Social Security on family planning services for young people had issued a guideline which, in effect, allowed a physician in certain exceptional cases to prescribe contraception for a girl under 16 years without her parents' consent. Mrs. Gillick, a mother of five daughters, challenged the guideline as being unlawful. The House of Lords rejected her claim and held that minors had the capacity to consent to medical treatment provided that they had sufficient maturity and understanding to decide on the matter in question. By this

¹⁷³ *Ibid* at para 8-9.

¹⁷⁴ See *Family Law Reform Act 1969* (UK), c 46, s 8(1).

¹⁷⁵ *Gillick v West Norfolk and Wisbech Area Health Authority*, [1985] UKHL 7; [1986] AC 112 [*Gillick*].

decision, the court recognized the autonomy and privacy rights of 'Gillick competent' children. In particular, the decision endorsed a functional determination of competence that is based on the child's level of maturity.

However, just as in Canada, the courts have been reluctant to find a minor competent where he or she exercises this right to refuse treatment, such as blood transfusion, which the court thinks is in his or her best interest.¹⁷⁶ In other cases of refusal of treatment, the courts have interpreted the *Gillick* decision as giving a minor the capacity to consent to treatment, but it does not remove parental rights to override the minor's decision.¹⁷⁷ In *Re R*,¹⁷⁸ the patient, a ward of the local authority, was suffering from recurring psychotic states. While in a calm state, she was able to convince a social worker that she no longer wished to take her medication. And in *Re W*,¹⁷⁹ the patient was in the care of the local authority, was suffering from anorexia, and did not want the treatment indicated for her. In both of these cases, the English Court of Appeal held that no child has the power to refuse healthcare such as to override consent that has been given by someone with parental responsibility, or by a court. The implication is that, following *Gillick*, a minor might be able to consent to treatment if he or she is of sufficient maturity; the minor may not refuse necessary treatment.¹⁸⁰

Recently, in *R (Axon) v Secretary of State for Health*,¹⁸¹ a case whose facts are similar to *Gillick*, the rights and autonomy of minors to make decisions about their own lives was emphasized. Although this case did not decide whether a minor can refuse treatment irrespective of the views of her parents and the court, it stressed the importance of the

¹⁷⁶ See for example, *Re E (a Minor) (Wardship: Medical Treatment)*, [1993] 1 FLR 386.

¹⁷⁷ See *Re R (A Minor) (Wardship: Consent to Treatment)*, [1992] Fam 11, [1991] 4 All ER 177 (CA); *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)*, [1993] Fam 64, [1992] 4 All ER 627 (CA).

¹⁷⁸ *Re R (A Minor) (Wardship: Consent to Treatment)*, *ibid.*

¹⁷⁹ *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)*, *ibid.*

¹⁸⁰ The decisions in *Re R* and *Re W* were, however, not followed in *Re Alex* (2004) 31 Fam LR 503 at 532 and in *Re Marion* (1992), 175 CLR 218.

¹⁸¹ *R (Axon) v Secretary of State for Health*, [2006] EWHC 37, [2006] 2 WLR 1130.

minor's right to participate in decision-making about her health, and implies that as she matures, she may be able to exclude others from the decision process. It would seem that the right to participate in healthcare decision-making does not equate with the right to make the decision. Yet, if the basis of a minor's involvement in medical decisions is autonomy rather than welfare, then it is expected that the decisions of competent minors should be respected even where the consequences of those decisions are grave.¹⁸² Although, it may be difficult for a minor to demonstrate competence to understand decisions involving life and death, what is argued here is that the assessment must be a functional one. It must not depend on the age of the minor.

3.1.2.3.3 Competence of Minors in Australia

The High Court of Australia adopted the decision in *Gillick in Secretary, Department of Health and Community Services v JWB and SMB* (Marion's case).¹⁸³ Consequently, in Australia, competence of the minor to consent to treatment is not determined by age but by his or her capacity to fully understand the implication of the treatment contemplated. However, as in the United Kingdom, courts in Australia have interpreted the right of a competent minor to refuse necessary treatment to be subject to the *parens patriae* jurisdiction of the court.¹⁸⁴ For example, in *Minister for Health v AS*,¹⁸⁵ the Supreme Court of Western Australia said that the court would almost always override a child's decision to refuse life-saving or life-prolonging treatment, in accordance with the child's best interests. Although the views of the child are relevant to the "best interests" analysis, and the court would exercise great caution in

¹⁸² See Rachel Taylor, "Reversing the Retreat from *Gillick*? *R (Axon) v Secretary of State for Health*" (2007) *Child and Family Law Quarterly* 19(1) 81 at 93-94.

¹⁸³ *Secretary, Department of Health and Community Services v JWB and SMB* (Marion's case) (1992), 175 CLR 218.

¹⁸⁴ See *Director General, New South Wales Department of Community Services v Y*, [1999] NSWSC 644 (AustLI), at paras. 99-103.

¹⁸⁵ *Minister for Health v AS*, [2004] WASC 286, 33 Fam LR 223.

overturning them, the child's views alone are not determinative, regardless of the child's maturity.¹⁸⁶

3.1.2.3.4 Competence of Minors in South Africa

The position in South Africa is similar. According to the *South African Children's Act, 2005*,¹⁸⁷ a minor¹⁸⁸ may consent to his or her own medical treatment or to that of his or her child if the minor is over 12 years of age, is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the treatment.¹⁸⁹ However, the competent minor requires the assistance of his or her parent or guardian to be able to consent to surgery.¹⁹⁰ The consent of a parent or guardian is required where the minor is under 12 years of age, or over but lacks sufficient maturity or ability to understand the benefits, risks and social implications of the treatment or surgery.¹⁹¹ However, such parental consent must take into consideration any expressed wishes of the minor, bearing in mind his or her age, maturity and stage of development.¹⁹²

The right of minors to consent to treatment or, with assistance, to surgery does not include the right to refuse life-saving treatment. Where a minor unreasonably withholds

¹⁸⁶ *Re: Marions' case*, *supra* note 183 at 280 para 23.

¹⁸⁷ *Children's Act*, (S Afr), No 38 of 2005 assented to June 8, 2006 [*Children's Act*] [not yet proclaimed in force] amended by *Children's Amendment Act*, (S Afr), No 41 of 2007 and by *Child Justice Act*, (S Afr), No 75 of 2008 [with effect from April 1, 2010]. The Current law, though soon to be repealed, is the *Child Care Act*, (S Afr), No 74 of 1983 s 39. See Prinslean Mahery & Paula Proudlock, " Legal Guide to Age Thresholds for Children" September 2008 online: www.ci.org.za/depts/ci/plr/pdf/factsht/AG_0908_print.pdf .

¹⁸⁸ A minor is a person below 18 years of age. See *Children's Act* 38 of 2005 s 17. This section came into effect from July 1, 2007.

¹⁸⁹ *Children's Act*, (S Afr), No 38 of 2005 s 129(2).

¹⁹⁰ *Children's Act*, s 129(3). The Act does not specify what kind of assistance is needed. Perhaps what is intended is that the consent of the parent or guardian is required in addition to that of the child. This is the interpretation that is given to it here.

¹⁹¹ *Children's Act*, s 129(4) and (5).

¹⁹² *Children's Act*, s 31(1).

consent, or the parent or guardian unreasonably refuses to give consent or to assist a minor to give consent, the Minister may give consent.¹⁹³ In all instances where another person who is required to give consent withholds such consent, the High Court or children's court may consent to the treatment or surgery.¹⁹⁴ So far, except for some variation on specifics, the law in South Africa accords with those in the other countries discussed. First, competence is functional and not by age, although South Africa sets a definite age limit below which the law need not assess competence. But, where the treatment or surgery is for the purpose of terminating a pregnancy, a minor of any age may consent to such treatment or surgery; she does not require parental assistance to do so.¹⁹⁵ Second, a mature minor cannot refuse necessary medical treatment. As well, parents or a guardian cannot simply withhold consent to necessary treatment or surgery for religious reasons. According to the Act:

No parent, guardian or care-giver of a child may refuse to assist a child...or withhold consent...by reason only of religious beliefs or other beliefs, unless that parent or guardian can show that there is a medically accepted alternative choice to the medical treatment or surgical operation concerned.¹⁹⁶

This provision codifies the common law practice of overriding, in most cases, the refusal by parents or guardians to consent to life saving treatment, like giving of blood or blood products, on the grounds of religious belief. But here, South African legislation requires the parent or guardian to provide an alternative medical treatment to justify refusal of the treatment offered.

3.1.2.3.5 Competence of Minors in the United States

In the United States, the competence of minors to make healthcare decisions is well established in both federal and state policy.¹⁹⁷ A research study that was conducted to

¹⁹³ *Children's Act*, s 129(7) and (8).

¹⁹⁴ *Children's Act*, s 129(9).

¹⁹⁵ See *Choice on Termination of Pregnancy Act*, 1996 (A Sfr), No 92 of 1996 s 5(2).

¹⁹⁶ *Children's Act* S 129(10).

¹⁹⁷ Heather Boonstra and Elizabeth Nash, "Minors and the Right to Consent to Health Care" [2000] *The Guttmacher Report on Public Policy*.

determine the policies at the federal and state level found that with the exception of abortion, many states explicitly authorize minors to access reproductive healthcare and other sensitive services, such as treatment for alcohol and drug abuse and outpatient mental health care, without requiring parental consent or notification.¹⁹⁸

The policy reason for the explicit authorization is to protect the privacy rights of the minor, as well as the recognition that requiring parental consent or notification may dissuade minors, such as those who are sexually active, pregnant, infected with a sexually transmitted disease, abuse drugs or alcohol or suffer from emotional or psychological problem, from seeking needed care.¹⁹⁹

Several attempts have been made to restore the traditional parental control over minors' reproductive health care decisions.²⁰⁰ These attempts are based on the notion that before the age of majority,²⁰¹ a minor lacks the "experience" and "judgment" to make "fully informed decisions."²⁰² Hence, as argued, it is acceptable to override the decision of a minor in order to protect him or her from making wrong decisions due to his or her inexperience, except in cases of emergency where parental consent cannot be

¹⁹⁸ *Ibid* at 4.

¹⁹⁹ *Ibid* at 4.

²⁰⁰ For example Conservatives in the US Congress have repeatedly made efforts to require parental consent or notification before a minor receives contraceptive services and other reproductive health care under the Title X family planning program, such efforts have however not been fruitful. At the State level, Texas legislature, for example, voted in 1997 to prohibit the use of state funds to provide prescription drugs including birth control pills, and medications for STDs to minors without parental consent, and in 2000, the South Carolina legislature considered a bill to prohibit the use of state funds to provide condoms and other contraceptives to minors whose parents have registered an objection to the provision of such services to their child. This bill was passed by the House of Representatives but dropped at the committee hearing in the Senate. See generally, Boonstra and Nash, *ibid* at 4.

²⁰¹ That is 18 years in all but four states. See Boonstra and Nash, *ibid*.

²⁰² *Ibid*.

obtained, or in the case of emancipated²⁰³ or mature minors. These attempts were, however, unsuccessful.

Under common law, as in other jurisdictions, the capacity of competent minors to consent to treatment, including having an abortion, is recognized,²⁰⁴ but whether such a right extends to refusing necessary treatment is, as in other jurisdictions, not clear.

3.1.2.4 Competence of Minors: Conclusion

What is clear in all the jurisdictions is that a minor is not, by reason solely of being below the age of majority, incompetent to make treatment decisions. Although legislation, in some cases, provide for age of consent, in all the jurisdictions analyzed above, competence is not a function of age, but of maturity, and assessment is subjective both to the particular minor and her level of maturity, and to the decision to be made. It is also reasonably clear that courts are, generally, reluctant to allow a mature minor to refuse necessary treatment which is in his or her best interests. In such cases, the minor may be subjected to a more rigorous assessment of maturity,²⁰⁵ or the court may exercise its *parens patriae* jurisdiction to authorize treatment.

Beyond the foregoing gate-keeper competence, is the requirement that consent should proceed from the patient voluntarily, without fraud, duress or undue influence. This requirement is the focus of the next section.

²⁰³ An emancipated minor is one who is in a situation which allows him or her to legally make decisions for himself or herself. An example is a minor who is married.

²⁰⁴ *Planned Parenthood of Central Missouri v Danforth, Attorney General of Missouri*, 428 US 52 (1976).

²⁰⁵ As was held in *AC v Manitoba (Director of Child and Family Services)*, *supra* note 104.

3.2 Voluntariness as an Element of Informed Consent

A valid consent is one which is given voluntarily, without coercion, undue influence or misrepresentation,²⁰⁶ and in which the will of the person giving it is neither overwhelmed nor undermined.²⁰⁷ To act voluntarily implies that the person acts deliberately out of his or her own volition or free will and in the absence of fraud, duress, undue influence or misrepresentation. Voluntariness also implies the absence of oppression.²⁰⁸ Although oppression may manifest through duress or coercion, yet, as McLeod and Sherwin argue, it functions in complex and less obvious ways, and affects whole social groups rather than individuals. Hence, it tends to be overlooked.

Getting such consent in its strictest sense may be difficult, but not impossible. A patient's decision may be influenced by economic considerations,²⁰⁹ familial concern,²¹⁰ internalized norms, and even by the illness itself. Arguably, these factors influence the voluntariness of the decision and the extent to which it is representative of the patient's personal desires. The factors may be described as internal constraints and, depending on severity, if they do not affect the competence of the patient to be self-determining, they may be accepted as a part of the patient and not necessarily as undue influence.

But, there are instances where the persuasion and influence of other persons are so pronounced that the decision made cannot rightly be attributed to the patient's

²⁰⁶ *Norberg v Wynrib* (1992), 92 DLR (4th) 449 at 457 (SCC).

²⁰⁷ Neil C Manson & Onora O'Neill, *supra* note 52 at 17.

²⁰⁸ Carolyn McLeod & Susan Sherwin, "Relational Autonomy, Self-Trust, and Health Care for Patients Who are Oppressed" in Mackenzie & Stoljar 259.

²⁰⁹ In *Reibl v Hughes*, the Supreme Court of Canada acknowledged that the fact that the patient was only 18 months from being eligible for full pension would have significantly affected his decision about the nature and timing of treatment.

²¹⁰ See NS Jecker, "Being a Burden on Others" (1993) 4:1 J of Clinical Ethics 16.

voluntary exercise of will.²¹¹ Or, though not as pronounced, yet it interferes with a patient's ability to act autonomously. Arguably, a patient may be persuaded to change his or her mind about a particular treatment provided the persuasion is not of such a nature that his or her will is undermined or overwhelmed. The question to ask, according to Lord Donaldson MR is "[d]oes the patient really mean what he says or is he merely saying it for a quiet life, to satisfy someone else or because the advice and persuasion to which he has been subjected is such that he can no longer think and decide for himself?"²¹²

In the Irish case of *JM v The Board of Management of St Vincent's Hospital*,²¹³ a patient's husband applied for a court order to have blood transfused in his unconscious wife notwithstanding that, while conscious, the patient had refused blood transfusion. Part of the evidence provided by the patient's husband in support of his application was that the patient is African and became a Jehovah's Witness on her marriage because it is part of her culture to adopt the religion of her husband upon marriage.²¹⁴ The court held that the patient refused blood transfusion "because of her cultural background and her desire to please her husband and not offend his sensibilities."²¹⁵ The court further held that the patient was "preoccupied with her husband" rather than her health and that if she was conscious, she would have approved of the decision taken and comforted by her husband's attitude.²¹⁶ Consequently, the court ordered the blood transfusion.

Clearly, the court recognized the effect on the patient's decision to refuse blood that is caused by her being a married woman from a culture which appears to place a premium

²¹¹ See the English Court of Appeal case of *Re T (Adult: Refusal of Medical Treatment)*, *supra* note 50. See also the Supreme Court of Canada decision in *Norberg v Wynrib*, *supra* note 206.

²¹² *Re T (Adult: Refusal of Medical Treatment)*, *ibid* at 797.

²¹³ *JM v The Board of Management of St Vincent's Hospital*, [2003] 1 IR 321.

²¹⁴ *Ibid* at 324.

²¹⁵ *Ibid* at 325.

²¹⁶ *Ibid*.

on pleasing one's husband. Arguably, the court viewed such cultural emphasis as an impediment to the patient's autonomy. This is further strengthened by the fact that the patient had, at some point accepted treatment, but changed her mind before the treatment was administered. Following the emergency situation that followed, it may be uncertain whether the patient would not have changed her mind again and accepted treatment. Based on this, it is arguable that the court did not treat the refusal of blood transfusion as proceeding autonomously from the patient.

However, the decision in this case raises certain concerns about agency and right to self-determination. Since the patient had indicated that she did not want blood treatment and there was no suggestion that she was incompetent, or unduly influenced at the time she made the decision, it is arguable that her right of self-determination was injured by the treatment order. On this view, the desire to please her husband by accepting his religious belief as her own is an autonomous act which the patient was at liberty to pursue. This is more so given that the patient's husband had assured her that she was free to accept the blood treatment and that he would not hold it against her. It is immaterial that the patient's decision was inconsistent, it is still, arguably autonomous. Provided she understood and appreciated the implication of accepting or refusing treatment, she is competent to make the decision, and this includes changing her mind and making a different decision.

It would seem that consent that is given because a patient feels she has no other choice is not truly voluntary and may be vitiated. In the Canadian case of *Norberg v Wynrib*,²¹⁷ a physician who knew about a patient's dependency on drugs, agreed to give her the drugs in return for sexual favours. The patient subsequently sued for damages, alleging among other things, battery. The physician raised the defence of consent. Three of the presiding judges held that the patient's consent to the sexual activity with the physician was not without duress, given the inequality of power between the parties, as well as

²¹⁷ *Norberg v Wynrib*, *supra* note 206.

the exploitative nature of the relationship. Two of the judges found the physician liable for breach of fiduciary duty. One of the presiding judges found the physician liable for breach of his professional duty even though, according to this judge, the patient's consent to sexual contact was valid.

Also vitiated is consent obtained when a physician deliberately misrepresents facts to induce the patient to consent. This contemplates fraudulent misrepresentation, such as where a physician misrepresents the procedure actually performed, for example, abscess instead of abortion.²¹⁸ It does not include innocent misrepresentations where the intention to mislead the patient is absent.²¹⁹ Where a physician fails to disclose, for example, an error in a previous surgery, and subsequently obtains consent to a second surgery to repair the initial error, the physician is deemed to have misrepresented by omission. In *Gerula v Flores*,²²⁰ a physician mistakenly performed a surgical operation on a patient's fourth vertebra instead of the third to which consent was given. The physician subsequently obtained consent for a second surgery without informing the patient that the second surgery was necessary to repair the initial mistake. The Ontario Court of Appeal held that the misrepresentation was deliberate and vitiated the patient's consent to the second operation. The court also held that both the first and second operation amounted to battery.

The ability of a patient to act autonomously may also be affected by social factors, such as sexism and patriarchy, which either limit the options available to the patient, or actively prevents her from deciding what she wants. This runs a risk of generalization

²¹⁸ See the American case of *Hobbs v Kizer*, 263 F 681 (Ct App 8th Ct 1916).

²¹⁹ See *kita v Braig* (1992), 71 BCLR (2d) 135 (CA), the physician led a patient's wife to believe that he is experienced as an ear, nose and throat specialist, without specifying that his experience was limited to the three occasions he carried out a ligation as a resident and under the supervision of an experienced surgeon. The court held that it was an innocent misrepresentation since the physician did not know that his experience mattered to the patient's wife. He had not intentionally concealed the added information in order to induce consent.

²²⁰ *Gerula v Flores* (1995), 126 DLR (4th) 506 (Ont CA).

for, it will be incorrect to conclude that every person who belongs to a class of persons that is subject to oppression is unable to exercise full autonomy. However, it is arguable that oppression interferes with an individual's ability to act autonomously. As McLeod and Sherwin states, "[i]ndividual members of oppressed groups are affected to varying degrees by the forms of oppression that are endemic to their society; some manage to overcome the oppressive circumstances of their lives largely unscathed."²²¹

A female patient who is socialized to be subservient may not trust herself enough to make decisions affecting her health even where she is invited to do so, or, presented with options, she may choose one which is likely to be approved by the persons to whom she is subservient. Consequently, for a patient to be maximally able to exercise autonomy, it is necessary that sources of oppression be eliminated.

A competent patient requires information to be able to make a decision. This forms part of a physician's duty of care. The nature and extent of this duty is explored next under disclosure as an element of informed consent.

3.3 Disclosure as an Element of Informed Consent

The requirement that physicians must obtain the informed consent of patients before they intervene medically, places a duty on them to provide patients with material information to enable each patient to make an informed decision. As noted in Chapter Two, a physician who fails to provide, or who provides insufficient information for an informed decision is in breach of his or her duty of care and may be liable in negligence. Adequate disclosure and informed consent are, arguably, intricately linked: for consent to be informed, the patient must receive adequate disclosure. The nature and scope of information required in discharge of this duty, and to make patient consent informed varies according to the decision to be made and according to the patient making it. The court in the US case of *Canterbury v Spence* held:

²²¹ Carolyn McLeod & Susan Sherwin, *supra* note 208 at 260.

[T]he patient's right of self-decision shapes the boundaries of the duty to reveal. That right can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The scope of the physician's communications to the patient then must be measured by the patient's need, and that need is the information material to the decision. Thus the test for determining whether a particular peril must be divulged is its materiality to the patient's decision: all risks potentially affecting the decision must be unmasked.²²²

The foregoing dictum aptly captures the true import of disclosure necessary for informed consent: adequacy of disclosure as determined by the patient's need.²²³ It has, however, been contended that while measuring adequacy of disclosure by the need of the patient may be morally ideal, it would amount to an undue demand on physicians who may lack the foresight to know what information a patient needs in order to give an informed consent, especially where there is a possibility the patient himself does not know this until the risk materializes.²²⁴ Hence, standards have been introduced to create a semblance of uniformity in meeting the requirements in issue. In other words, the desire for predictability necessitates the introduction of rules by which adequate disclosure may be measured. Such rules or standards are either patient-based or physician-based. Each of the standards is further analyzed. However, the importance of disclosure to informed consent and to the patient's health will be discussed first.

3.3.1 *Justifying the Need for Disclosure*

It has already been stated that information is essential to giving an informed consent, for it provides the fodder required for the decision making process. Disclosure performs two important functions: it confers therapeutic benefit and empowers the patient. Studies indicate that patients who are knowledgeable about their health condition and involved in the decision making process are more likely to comply with their treatment

²²² *Canterbury v Spence*, *supra* note 44 at 786-87.

²²³ Although the court, later in the judgment held that the standard is an objective one based on what a reasonable patient would want to be told.

²²⁴ Jaime Staples King & Benjamin Moulton, "Rethinking Informed Consent: The Case for Shared Medical Decision-Making" (2006) 32 Am J L & Med 429.

regimen. They also have reduced levels of anxiety, recover faster from surgery, and have enhanced ability to protect themselves, such as by recognizing untoward side effects.²²⁵ Consequently, they are more likely to emerge from therapy in better health.²²⁶ In its empowerment function, disclosure provides the patient with the information he or she needs to be self-determining.

The therapeutic benefits of disclosure have been criticized. It is argued that in those instances where the efficacy of a medical procedure is not certain so that a lot depends on the blind faith of the patient, disclosure of the existing uncertainties and risks may rob him or her of the placebo component of treatment.²²⁷ It is generally acknowledged by physicians that patients are cured not only by an actual treatment, but also by the knowledge that they have undergone a medical procedure and that relief is imminent.²²⁸ It is also contended that disclosure of risks and side effects may result in patients refusing necessary treatment out of fear of risks that might not occur and that it may, in some cases, create undue anxiety and cause a relapse. However, these fears are neither justified nor supported by available empirical evidence. Rather, existing empirical evidence shows that disclosure is beneficial.²²⁹

A study on the attitudes of cancer patients and their families toward the disclosure of terminal illness shows that although some patients would rather not be informed that their illness is terminal, a majority of patients would want to be informed of the nature

²²⁵ President's Commission Report, *supra* note 22 at 69.

²²⁶ *Ibid* at 68.

²²⁷ See Gilbert Honigfeld, "Non-Specific Factors in Treatment II: Review of Social-Psychological Factors" (1964) 25 *Diseases of the Nervous System* 225.

²²⁸ President's Commission Report, *supra* note 22 at 99.

²²⁹ See ED Myers & EJ Calvert, "The Effect of Forewarning on the Occurrence of Side Effects and the Discontinuance of Medication in Patients on Amitriptyline" (1973) 122 *Brit J of Psychiatry* 461; "The Effects of Forewarning on the Occurrence of Side Effects and Discontinuation of Medication in Patients on Dothiepin" (1976) 4 *J of Int'l Med Research* 237; Louis A Morris & David E Kanouse, "Informing Patients about Side effects" (1982) 5 *J of behave Med* 363.

of their illness, including whether it is terminal.²³⁰ It was also found that patients who were informed about their health status had a better emotional and psychological adjustment to their health status than patients who reported guessing about their condition or learning about it by chance. This, as confirmed by empirical evidence, suggests that more often than not, the hypothesized negative reaction or outcomes of disclosure such as anxiety, stress, and deterioration, do not materialize.²³¹ Even where disclosure produces anxiety, a US Supreme Court Justice opines that it is the very nature of informed consent requirements, as well as the reason for their existence, that they produce some anxiety in the patient and influence the choice he or she makes.²³² According to this judge, “it is an entirely salutary reason.”²³³ Physicians are, however, generally reluctant to disclose “bad news” to patients and would either avoid disclosure entirely, or give a vague, generalized or round-about disclosure.²³⁴

Studies have also demonstrated that preoperative counseling tends to reduce anxiety and complications during convalescence.²³⁵ It is hypothesized that the stress-reducing

²³⁰ Young Ho Yun *et al*, “The Attitudes of Cancer Patients and their Families Toward the Disclosure of Terminal Illness” (2004) 22 J Clin Oncol 307; in the survey carried out by the President’s Commission, it was found that there was an “unflinching desire” by the public for facts about their condition including “dismal facts”. See President’s Commission Report, *supra* note 22 at 75.

²³¹ See Kimberly A Quaid *et al*, “Informed Consent for a Prescription Drug: Impact of Disclosed Information on Patient Understanding and Medical Outcomes” (1990) 15 Patient Education and Counseling 249.

²³² Justice Byron White in *Thornburgh v American College of Obstetricians*, (1986) 106 S Ct 2169 at 2199-2200 (White J dissenting).

²³³ *Thornburgh v American College of Obstetricians*, (1986) 106 S Ct 2169 at 2200.

²³⁴ This attitude appears to be changing. See Walter F Baile *et al*, “Oncologists’ Attitudes Toward and Practices in Giving Bad News: An Exploratory Study” (2002) 20 J Clin Oncol 2189; Ali H Aljubran, “The Attitude Towards Disclosure of Bad News to Cancer Patients in Saudi Arabia” (2010) 30(2) Annals of Saudi Medicine 141; Gregory W Rhunke *et al*, “Ethical Decision Making and Patient Autonomy: A Comparison of Physicians and Patients in Japan and the United States” (2000) 118(4) Chest 1172.

²³⁵ See for example, Lawrence D Egbert *et al*, “Reduction of Post-Operative Pain by Encouragement and Instructions to Patients” (1964) 270 New Eng J Med 825; John F Wilson, “Behavioural Preparation for Surgery: Benefit or Harm (1981) 4 J of Behav Med 79; President’s Commission Report at 100.

effects of preparatory information is achieved by stimulating an initial worry prior to the medical treatment and, consequently, it provides emotional inoculation for the patient to be better able to cope with the stress.²³⁶ Other hypotheses are that disclosure of information serves to produce accurate expectations, and the information allows a patient to retain a measure of control over adverse post-treatment outcomes by being able to predict them.²³⁷

Having identified that disclosure is necessary for a proper exercise of the right to self-determination, and given that it is better that a patient is informed than not, it is necessary to find out how extensive such disclosure should be. As mentioned earlier, the ideal is one which facilitates informing the decision made by a patient. This excludes an extensive recitation of facts and statistics which may have no meaning to the patient. In this respect, two standards have been identified across jurisdictions like Canada, the United States, the United Kingdom and South Africa. They are professional and patient-based standards. In as much as each standard has advantages, it also has disadvantages. These are discussed next.

3.3.2 *Standards of Disclosure*

3.3.2.1 The Professional Standard of Disclosure

The professional standard of information disclosure contemplates disclosure of information according to the custom of the medical profession. Here, the nature and materiality of information to be disclosed is determined by the physician in line with the approved conduct of his or her professional colleagues. Under this standard, the duty of

²³⁶ See Irving Janis & Leon Mann, *Decision Making: A Psychological Analysis of Conflict, Choice, and Commitment* (New York: Free Press, 1977) at 388-392.

²³⁷ See generally President's Commission Report, *supra* note 22 at 99-101. See also Jean E Johnson, "Effects of Accurate Expectations about Sensations on the Sensory and Distress Components of Pain" (1976) 27 *J of Personality and Soc Psychology* 809; James R Averill, "Personal Control Over Adverse Stimuli and its Relationship to Stress" (1973) 80 *Psychological Bulletin* 286.

the physician is to disclose such information as an objective and prudent physician in the same field would provide.²³⁸ It follows that if the standard practice of prudent members of the profession is not to disclose a certain piece of information, the physician will be justified in not disclosing that information. Expert testimony would be required to establish what a reasonable physician would have done. This standard is still the law in the United Kingdom²³⁹ and in some states in the United States.²⁴⁰

The key attraction of the professional standard for the physician is the relative certainty of the nature and scope of information that is required. A general criticism of the standard is that it is uncertain that there is an accepted custom of disclosure of information even among specialists in the same field.²⁴¹ Secondly, it is argued that even if such a custom exists, pervasive negligence may be perpetuated with impunity as professionals would offer the same inadequate disclosure, or retain the discretion to decide the level of disclosure to provide.²⁴² In the main, the professional standard has been criticized on the grounds that it constrains patient autonomy and fosters

²³⁸ King & Moulton, *supra* note 224.

²³⁹ See *Sidaway v Bethlehem Royal Hospital Governors*, [1985] AC 871 [*Sidaway*]. See also *Bolam v Friern Hospital Management Committee*, (1957) 2 All ER 118 [*Bolam*]. In *Bolam*, it was established that as long as there is a body of reasonable physicians who would have acted the way the particular physician did then no breach of duty or negligence would be found ["the *Bolam* test"]. Following *Sidaway*, courts have been able to circumvent the strict application of the *Bolam* test by holding that where knowledge of a risk is obviously necessary for an informed decision, such that any reasonable physician ought to have disclosed it, the court is not under compulsion to accept the evidence of the medical profession without a logical basis. See *Bolitho v City & Hackney Health Authority*, (1997) 4 All E.R 771. See also Margot Brazier & Jose Miola, "Bye-Bye *Bolam*: A Medical Litigation Revolution?" (2000) 8 Med L Rev 85; General Medical Council, *Seeking Patients' Consent: The Ethical Considerations* (1999), available online at

http://www.gmc-uk.org/standards/consent.htm#note_2; Michael A Jones, "Informed Consent and Other Fairy Stories" [1999] Med L R 103.

²⁴⁰ For a listing of states in the United States which apply the professional standard of disclosure, see King & Moulton, *supra* note 224 Appendix A.

²⁴¹ See Beauchamp & Childress, *supra* note 5 at 148.

²⁴² *Ibid.*

paternalism.²⁴³ Consequently, the professional standard has been rejected in Canada,²⁴⁴ Australia,²⁴⁵ South Africa,²⁴⁶ and some states in the United States.²⁴⁷

3.3.2.2 The Patient Standard of Disclosure

The patient standard of disclosure requires that the information to be disclosed should be determined by reference to the patient rather than the physician. This standard places the interests of the patient at the center of the disclosure requirement. The 1972 U.S. cases of *Canterbury v Spence*²⁴⁸ and *Cobbs v Grant*²⁴⁹ were instrumental in the shift from what used to be a physician-based standard to a more patient-centered approach.²⁵⁰ The patient standard requires adequacy of disclosure to be calibrated by jury assessments of what a reasonable patient in the plaintiff's position would expect to be told prior to making a decision about treatment.²⁵¹ The court did not altogether deny the relevance of professional expertise. Rather, the court assigned medical expertise a substantial role in determining diagnosis and treatment options, but left the preferred option to the patient.²⁵²

Under the patient standard, the test for determining whether a risk needs to be disclosed is its materiality to the patient's decision.²⁵³ In *Reibl v Hughes*, it was held that the relationship between surgeon and patient gives rise to a duty upon the surgeon to

²⁴³ *Ibid.*

²⁴⁴ See the landmark case of *Reibl*, *supra* note 27.

²⁴⁵ See *Rogers v Whittaker*, *supra* note 44.

²⁴⁶ See *Castell v De Greef*, *supra* note 44.

²⁴⁷ See King & Moulton, *supra* note 224 Appendix A for a list of countries applying a patient based standard.

²⁴⁸ 464 F2d 772 (DC Cir 1972).

²⁴⁹ *Cobbs v Grant*, 8 Cal 3d 229, 104 Cal Rptr 505, 502 P 2d 1 (1972).

²⁵⁰ See David M Studdert *et al*, "Geographic Variation in Informed Consent Law: Two Standards for Disclosure of Treatment Risks" (2007) 4:1 J Empirical Legal Stud 103.

²⁵¹ According to Robinson J in *Canterbury v Spence*, 464 F2d 772 (DC Cir, 1972) at 781, "[i]t is the prerogative of the patient, not the physician to determine for himself the direction in which his interests seem to lie."

²⁵² *Canterbury v Spence*, *supra* note 44 at 785-87.

²⁵³ *Ibid* at 786.

disclose to the patient all material risks attending the surgery which is recommended. Relying on its earlier decision in *Hopp v Lepp*, the court stated:

In summary, the decided cases appear to indicate that, in obtaining the consent of a patient for the performance upon him of a surgical operation, a surgeon, generally, should answer any specific questions posed by the patient as to the risks involved and should, without being questioned, disclose to him the nature of the proposed operation, its gravity, any material risks and any special or unusual risks attendant upon the performance of the operation. However, having said that, it should be added that the scope of the duty of disclosure and whether or not it has been breached are matters which must be decided in relation to the circumstances of each particular case.²⁵⁴

Further, the Court held that even if a certain risk is a mere possibility which ordinarily need not be disclosed, yet if its occurrence carries serious consequences, as for example, paralysis or even death, it should be regarded as a material risk requiring disclosure.²⁵⁵ What is material is not limited to risks, but includes alternatives to treatment and the risks in those alternatives. According to Picard & Robertson

It is now well established that the duty of disclosure is not confined to risks, but extends to other material information which a reasonable patient would want to have. In particular, the patient must be informed of any available alternatives to the treatment being proposed, as well as the material risks associated with those alternatives.²⁵⁶

From the foregoing, it is evident that materiality is determined objectively. Thus, the physician is only required to disclose those risks which “a reasonable person, in what the physician knows or should know to be the patient’s position, would be likely to attach significance to...”²⁵⁷ This standard made a great impact on patient autonomy by concentrating more powers in the patient than is generally available to him or her under the professional standard, and sought to redress the inequality of power between the

²⁵⁴ *Reibl, supra* note 27 at 4.

²⁵⁵ *Ibid.*

²⁵⁶ Picard & Robertson, *supra* note 102 at 130.

²⁵⁷ *Canterbury v Spence, supra* note 44 at 787 (quoting Jon R Waltz & Thomas W Scheuneman, “Informed Consent to Therapy (1970) 64 NW U L Rev 628 at 639-40.

physician and the patient.²⁵⁸ The objective patient standard also protects the physician from liability where a seemingly insignificant or extremely unlikely risk is not disclosed.²⁵⁹ The standard performs this function by limiting the scope of disclosure to what a reasonable person in the patient's position would want to know. In other words, the objective patient-based standard protects physicians from the whims and idiosyncrasies of individual patients.²⁶⁰ Both *Canterbury v Spence* and *Cobbs v Grant* were relied on by Australia,²⁶¹ New Zealand,²⁶² Canada,²⁶³ and South Africa²⁶⁴ in adopting the objective patient-based standard.

This standard too has its shortcomings. The concept of "reasonable patient" is flawed on several grounds.²⁶⁵ First, patients hardly agree about what risks are "material" to a medical treatment decision.²⁶⁶ Where treatment options have closely related risks and benefits, patients tend to judge the same set of treatments differently, depending on their risk aversion or other value judgment, especially where the risk involved affects the quality of life of the patient.²⁶⁷ Second, because even "reasonable" patients'

²⁵⁸ Dennis Klimchuk & Vaughan Black, "Comments" (1997) 76 Can Bar Rev 569 at 571; Gerald Robertson, "Informed Consent ten Years Later: The Impact of *Reibl v Hughes*" (1991) 70:3 Can Bar Rev 423; Patricia Peppin, "Informed Consent" in Jocelyn Downie, Timothy Caulfield & Colleen Flood eds, *Canadian Health Law and Policy* 4th ed (Canada: LexisNexis, 2011) 153.

²⁵⁹ King & Moulton, *supra* note 224 at 458.

²⁶⁰ *Ibid* at 443.

²⁶¹ *Rogers v Whittaker*, *supra* note 44; *Naxakis v Western General Hospital*, (1999) 73 ALJR 782.

²⁶² See *R v Medical Council*, (High Court, Auckland HC11/1996, 8 July 1996).

²⁶³ *Reibl v Hughes*, *supra* note 27.

²⁶⁴ *Castell v De Greef*, *supra* note 44. The court relied on *Reibl v Hughes* which was influenced by *Cobbs* and *Canterbury*.

²⁶⁵ Sidney T Bogardus, Eric Holmboe & James F Jekel, "Perils, Pitfalls and Possibilities in talking about Medical Risk" (1999) 281:11 JAMA 1037.

²⁶⁶ *Ibid* at 1039; Lorne E Rozovsky, *The Canadian Law of Consent to Treatment* 2d ed (Toronto: Butterworths, 1997) at 9. See also *Joshi (Guardian ad litem of) v Woolley*, (1995), 4 BCLR (3d) 208 (SC).

²⁶⁷ Bogardus, Holmboe & Jekel, *ibid*. See also Steven H Woolf, "The Logic and Limits of Shared Decision Making" (2001) 166 J Urology 244.

preferences vary, the physician's ability to determine what, in a particular circumstance is material, would involve guesswork and may, consequently, be unreliable.²⁶⁸

The pertinent questions are: who decides what is reasonable in a particular instance? How is reasonability determined? What qualifies as reasonable? Perhaps, the notion of reasonability is meant to operate as a sieve to separate those whose conduct conforms to the mainstream from those whose conduct does not conform. This is because inherent in the idea of reasonability is an acknowledgment that there are unreasonable individuals. Perhaps it is in order that physicians may be protected from liability for failing to provide the kind of information that would meet the needs of the class of persons who do not fit within the reasonable group that the duty to disclose is measured by an objective standard.²⁶⁹

Third, an objective standard suffers from the same flaw as the professional standard which courts are abandoning. In this respect, just as adherence to the practice of a reasonable body of medical opinion denies the patient the right to determine the information he or she needs to be able to make an informed decision, so does adhering to what a class of reasonable persons would expect to be told. Both do not take into account the particular patient's need.

Fourth, and following from the above, the objective patient standard, in a sense, is paternalistic. It assumes that a particular patient would want to know what a reasonable person would want to be told, whether or not the patient actually wants that information. In other words, it assumes knowledge of what a patient would want to know without inquiring into the need of the actual patient. Individuals differ due to unconventional belief systems, widely varying values, unusual health problems, and unique family history. Consequently, reasonable disclosure, in the case of a patient who

²⁶⁸ See generally, King & Moulton, *supra* note 224.

²⁶⁹ JK Mason & RA McCall Smith, *Law and Medical Ethics* 4th ed (London: Butterworths, 1994) at 237.

requires a different kind of information other than what a hypothetical reasonable person would want, does not serve to make the patient informed. But, as already indicated, where the objective standard operates, provided the physician gives the patient information that a reasonable person would need, he or she is protected from liability from breach of his or her duty to disclose. Whether the consent that is obtained is truly informed is a different matter.

3.3.3 *When is Consent Informed?*

At what point then can consent be said to be informed? Is a patient's consent informed when he or she has received information a reasonable patient would require, however extensive it is? Or does a patient need to understand the information received for him or her to be informed? The answer to this depends on how informed consent as a concept is viewed. There are two notions and each is analyzed below.

3.3.3.1 The Physician's Duty to Disclose: First Notion of "Informed Consent"

This notion of "informed consent" concentrates on the duty of the physician to disclose information and only measures how much information is disclosed. This duty to disclose forms part of the duty of care a physician owes a patient. Whether the duty has been discharged or not is measured by standards. Where emphasis is on duty to disclose, the focus is properly on the nature and content of the physician's disclosure rather than on the understanding and consent of the patient.²⁷⁰ On this, the physician discharges the duty when he or she makes a reasonable effort to provide the patient with sufficient information even though, without any fault of the physician, the patient does not understand the information.²⁷¹

²⁷⁰ See "Opinion in *Canterbury v Spence*" reprinted in Thomas A Mappes & David DeGrazia, *Biomedical Ethics* 4th ed (New York: McGraw-Hill, 1996) 85 at 88 note 2.

²⁷¹ *Ibid.*

However, it is not certain that consent given without understanding the information provided is informed. The view of disclosure as including understanding is the second notion of informed consent and the subject of the next section.

3.3.3.2 Patient Comprehension: A Second Notion of “Informed Consent”

As earlier indicated, a physician may discharge his or her duty to disclose by providing adequate information which, assuming an objective patient standard, a reasonable patient would want. However, consent is not necessarily informed because there has been disclosure of information, irrespective of how extensive the disclosure may be. Rather, consent is informed when, following disclosure of information, the patient understands what has been disclosed and its implications. One patient may require more time, material, explanation, analogies, in order to understand what is disclosed. Another patient may not require any additional effort to understand. To be sure, the duty on physicians is not to explain all the details of every procedure and all the things that can possibly go wrong.²⁷² Rather, the duty of the physician is to do his or her best to make the patient understand the implications of treatment and, following this understanding, to decide if he or she wants that treatment or not.

That a patient must understand the information given to her is required in both the Nuremberg Code²⁷³ and in the Declaration of Helsinki (2008).²⁷⁴ The capacity to understand is, arguably, an important, if not the sole criterion for determining competency. Understanding is usually an issue where there is language limitation,²⁷⁵ or

²⁷² Allen M Linden & Bruce Feldthusen, *Canadian Tort Law* 8th ed (Markham: LexisNexis, 2006) at 182. See also *Kern v Forest*, [2010] BCJ No 136.

²⁷³ “...and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision.” Principle 1.

²⁷⁴ “After ensuring that the potential subject has understood the information, the physician or another appropriately qualified individual must then seek the potential subject’s freely-given informed consent, preferably in writing.” Declaration of Helsinki (2008) principle 24.

²⁷⁵ See for example *Reibl v Hughes*, *supra* note 27; *Ciarlariello v Schacter*, *supra* note 24.

unsophisticated patients with limited education,²⁷⁶ or patients under emotional or physical distress.²⁷⁷ As earlier argued, whether a patient has capacity depends on his or her ability to understand the information he or she is given, and utilize the same in making a health care decision. The physician has a moral duty to ensure that the patient understands the information that has been given.²⁷⁸ The understanding contemplated transcends the language used in communication to include understanding of the actual information disclosed.²⁷⁹ In *Ciarlariello v Schacter*,²⁸⁰ the Supreme Court of Canada observed that

Prior to *Reibl v Hughes*, there was some doubt as to whether the doctor had the duty to ensure that he was understood. However, Laskin CJC made it quite clear in that case that it was incumbent on the doctor to make sure that he was understood, particularly where it appears that the patient had some difficulty with the language spoken by the doctor.

Indeed, it is appropriate that the burden should be placed on the doctor to show that the patient comprehended the explanation and instructions given.²⁸¹

The above dictum by Justice Cory was not very well received, especially among academic writers.²⁸² Picard and Robertson argue that to require a doctor in every case to ensure that the patient understands the information given, and to place the burden of proving actual understanding on the physician “seems far too onerous and

²⁷⁶ See *Byciuk v Hollingsworth* at para 31-33; *Paradis (Litigation Guardian of) v Labow*, [1996] OJ 1326.

²⁷⁷ *Brown v Degani*, [1996] OJ No 126; *Smith v Tweedale* (1995) 4 BCLR (3d) 325, 55 BCAC 52. See generally *Malinowski v Schneider*, [2010] AJ No 1380.

²⁷⁸ See the Canadian case of *Reibl*, *supra* note 27.

²⁷⁹ Language barrier only serves to make the need to ensure comprehension more obvious. However, see *Martin v Findlay*, [2008] AJ No 462 (Alta CA) which suggests that the need to ensure understanding is limited to persons with language difficulties or other vulnerabilities. See also, Patricia Peppin, *supra* note 258 at 166-67.

²⁸⁰ *Ciarlariello v Schacter*, *supra* note 24.

²⁸¹ *Ibid* at 622.

²⁸² See for example, Picard & Robertson, *supra* note 102 at 161-64; Margaret A Somerville, “Structuring the Issues in Informed Consent” (1981) 26 McGill LJ 740 at 776-783; H Teff, “Consent to Medical Procedures: Paternalism, Self-Determination or Therapeutic Alliance” (1985) 101 LQ Rev 432 at 441.

impracticable a duty, especially in light of studies which indicate that many patients do not understand (or remember) what doctors tell them.”²⁸³ They suggest that the doctor should only be required to take reasonable steps to ensure that the patient understands.

The above suggestion by Picard and Robertson is practical and involves a hermeneutic approach towards enhancing patients’ understanding, and, thus, their autonomy. A physician would be deemed to have taken reasonable steps to ensure understanding if, where language is a barrier, he or she procures an interpreter, repeats explanations, asks the patient questions that require application or evaluation of the information given rather than a recital of the information, or enlists the assistance of family members to explain the information to the patient.²⁸⁴ However, given, as already acknowledged and supported by empirical evidence, that patients may not understand what doctors tell them, perhaps even after measures have been taken to ensure understanding, consent given by such patients, in the absence of actual understanding, may still not be informed.

The question becomes how the physician would satisfy himself that the patient actually understands. This issue is complex as understanding is subjective. Somerville suggests an “appearance” test. That is, if the patient appears to understand the information given, barring any indication to the contrary, the physician is entitled to assume that the patient actually understands.²⁸⁵ This suggestion seems ideal, especially as it may be difficult to measure understanding. However, as an added measure, the presence of a witness is helpful. The witness may also double as an interpreter or a facilitator, and should, preferably, be a family member. The family member may be enlisted to explain

²⁸³ Picard & Robertson, *ibid* at 137.

²⁸⁴ In *Byciuk v Hollingsworth*, [2004] AJ No 620 (Alta QB), it was held that where a physician relies on pamphlets or videos for disclosure, he or she has a higher obligation to ensure that the patient understands the content of the pamphlet or video.

²⁸⁵ Margaret A Somerville, *Consent to Medical Care* (Ottawa: Law Reform Commission of Canada, 1979) at 25.

the information to the patient. The family member should also be convinced that the patient understands the information given. While this may not ensure understanding in every situation, such situations will be the exceptions and are more likely to be in a very small minority.

Other means by which comprehension may be enhanced include the timing and method of conveying information.²⁸⁶ Canadian courts hold that unless there are compelling reasons to the contrary, the patient should be given sufficient time to consider and reflect on the information given, to consult family and other physicians if they wish, and so to come to an unhurried decision.²⁸⁷ Video presentations have been found to aid understanding.²⁸⁸ So are leaflets. However, it is argued that written disclosures are less effective than face-to-face communication.²⁸⁹ But this does not mean written disclosures are unhelpful. However, where leaflets or other printed materials are used, it is necessary, even prudent, to ensure that the information contained in them is accurate, simple rather than technical, and obvious.²⁹⁰ The patient should also be encouraged to ask questions, and their questions should be candidly answered by the physician.²⁹¹

When patients ask questions, it may be about matters that are important to them, or an indication of their understanding of the information. But encouraging patients to ask questions is not as simple as it sounds. Given the power and status imbalance between

²⁸⁶ Picard & Robertson, *supra* note 102 at 160-164.

²⁸⁷ See for example, *Sevier v Mann*, [1994] BCJ No. 18 at 29 (QL) (SC); *Layton v Wescott* (1992), 6 Alta LR (3d) 91 at 102; *Coughlin v Kuntz* (1987), 42 CCLT 142 at 176 (BCSC) aff'd (1989), 2 CCLT (2d) 42 (CA).

²⁸⁸ Julie Weston, Mary Hannah & Julia Downes, "Evaluating the Benefits of a Patient Information Video During the Informed Consent Process" (1997) 30 Patient Education and Counselling 239.

²⁸⁹ Karen Cox, "Informed Consent and Decision-making: Patients' Experiences of the Process of Recruitment to Phases I and II Anti-cancer Drug Trial" (2002) 46 Patient Education and Counselling 31.

²⁹⁰ *Finch v Carpenter*, [1993] BCJ No 1918 (QL) (SC). See also Picard & Robertson at 138-39.

²⁹¹ See generally *Hopp v Lepp*, *supra* 42; *Sinclair v Boulton* (1985), 33 CCLT 125 (BCSC).

a physician and the patient, unless patients are secure or comfortable in their relationship with the physician, they are unlikely to ask questions, or, in some cases, understand what they are told. They are also unlikely, perhaps out of self-consciousness, to disclose their lack of understanding to the physician.²⁹² It is also possible that, without medical knowledge, patients may not know much about their condition in order to ask meaningful questions. Or without seeking confirmation from the physician, patients may assume certain facts and hold on to such assumptions subconsciously, even where the physician discloses information that negatives those assumptions.²⁹³ It is important that physicians understand these factors and actively seek to ensure and enhance patient understanding.

The implication of the two notions of informed consent is that depending on where the focus is, the adoption of the same appellation “informed consent” for both of them is at best, confusing. It would seem that “informed consent” has a different, though not necessarily separate, meaning for the physician, as a professional, in his or her dealing with a patient, and for the physician, as a defendant, in an action alleging negligent non-disclosure. To the physician care giver, the primary focus of informed consent is on whether there is appropriate authorization by a competent patient to whom “sufficient” information has been disclosed. An appropriate authorization may be a signed consent form which may not necessarily embody the patient’s understanding. To the physician defendant, the focus narrows on whether adequate disclosure was made and whether the patient understood what was disclosed. Specifically, the question narrows to whether the particular risk which occurred had been disclosed, even though other risks

²⁹² Margaret A Somerville, “Legal Investigation of a Medical Investigation” (1981) 19 Alta L Rev 171 at 180.

²⁹³ *Ibid.*

may have been disclosed. However, it remains to be said that cases alleging lack of informed consent often turn on adequacy of disclosure.²⁹⁴

3.3.4 *Duty to Disclose: A Suggestion*

It is submitted that the focus must not be on the quantum of information supplied. A patient's interest may not be served by a detailed technical exposition of facts that has little relevance to his or her understanding of his or her medical condition, or material to the decision he or she has to make. Neither will a patient's interest be served by an artificially restricted scope of information. As the President's Commission noted:

Overwhelming patients with a mass of unintelligible technical data that they are ill-prepared to comprehend or use, particularly at what may be a stressful time, can be as destructive of the communication process, and its goal of enhanced understanding as giving too little information is. Similarly, reciting "all the facts" in a blunt, insensitive fashion can also be as destructive of the communication process, as well as the patient-professional relationship itself.²⁹⁵

Rather, empowering the patient to make an informed decision which accords with his or her values and preferences should be given central consideration. To this end, the goal of the physician should be "a tactful discussion, sensitive to the needs, intellectual capabilities, and emotional state of the particular patient at that time, in terms that the patient can understand, assimilate, and work with as part of the ongoing decision making process."²⁹⁶ In this respect, neither a professional standard nor a reasonable patient standard can claim hegemony. Both need integration. What physicians customarily disclose and what a reasonable patient may want to know, may not satisfy what a particular patient who is to undergo the medical procedure may want to know in order to make an intelligent decision.

²⁹⁴ See for example *Glaholt v Ross*, 2011 BCSC 113, [2011] BCJ No 1593; *Baert v Graham*, 2011 SKCA 21, [2011] SJ No 151; *Prevost v Ali*, 2011 SKCA 50, [2011] SJ No 247; *Paniccia Estate v Toal*, 2011 ABQB 326, [2011] AJ No 883.

²⁹⁵ President's Commission Report, *supra* note 22 at 71

²⁹⁶ *Ibid.*

The challenges inherent in the scope of disclosure which depends on the particular patient is acknowledged: patients often do not know what information they would need to decide on a course of treatment; physicians may lack fore-knowledge of what information a patient may need, and patients may unfairly rely on hindsight to create liability for the physician.²⁹⁷ In terms of cost, this standard may require time, intellectual and emotional effort, and a certain level of selflessness for physicians to meaningfully discuss issues that are of concern to patients. But these are necessary costs incurred in the pursuit of the larger goal to have informed patients. Given that the goal of disclosure is to promote patient autonomy, the objective standard does not fully protect such autonomy, though from the point of view of physicians, it is comparably more certain.

Where information that ought to have been, but was not disclosed to the patient, would have, if disclosed, affected his or her decision to undergo a particular treatment from which an injury resulted, the patient may be able to recover damages against the physician. As an element of an informed consent negligence action, causation performs an evidentiary function by linking the breach of a physician's duty to disclose to the injury suffered by the patient. Even though the concept of causation seems to be tied closely to disclosure as an element of informed consent, it will be treated separately because of its determinative value to whether an action for lack of informed consent succeeds.

3.4 Causation as an Evidential Element of Informed Consent Negligence Action

The duty of physicians to provide patients with information is part of their duty of care. A breach of this duty, where injury occurs, may result in an action against the physician in negligence. A patient who alleges non-disclosure or inadequate disclosure of information has the onus to establish a causal link between the physician's failure to

²⁹⁷ Beauchamp & Childress, *supra* note 102 at 150.

provide material information and his or her injury.²⁹⁸ In principle, the test is a subjective one. That is, the patient has to prove that he or she would have declined the treatment if proper disclosure had been made. This was the position in Canada before the Supreme Court of Canada's decision in *Reibl v Hughes*.²⁹⁹

In *Reibl*, the subjective test was rejected as inappropriate because it put a lot of emphasis on the patient's hindsight and exposes the physician to his or her bitterness.³⁰⁰ Instead, the court adopted an objective test, which focuses on whether a reasonable person in the circumstances of the patient would have declined treatment.³⁰¹ A patient would succeed only if he or she satisfies the court, on a balance of probabilities, that a reasonable person in his or her circumstance would have declined the treatment if proper disclosure was made.³⁰² This is also the test used in the US. The UK³⁰³ and Australia³⁰⁴ focus on what the particular patient would do had proper disclosure been made.

²⁹⁸ See *Reibl*, *supra* note 27.

²⁹⁹ See for example, *Strachan v Simpson*, [1979] 5 WWR 315 at 344 (BCSC); Ellen I Picard, Annotation, (1979) 10 CCLT 145.

³⁰⁰ *Reibl*, *supra* note 27 at 15.

³⁰¹ This test is described as a modified objective test in *Arndt v Smith* because it takes into account the circumstances of the patient, and to that extent, its objectivity is modified. The "modified objective" test has been described as a pernicious misnomer for what is straightforwardly objective. According to Klimchuk & Black, "the consideration of individual-specific factors in the *Reibl* standard marks no departure from its objectivity. Instead, some such factors must be considered to make the question "would a reasonable person have consented to this procedure?" intelligible." See Klimchuk & Black, *supra* note 258 at 571.

³⁰² In some cases, a claim may succeed even though a reasonable patient would have accepted treatment. An example is where the patient would have deferred the treatment till a later time. See *Reibl*, *supra* note 27. On the other hand, a patient may be unsuccessful, where it is shown that though a reasonable patient would have declined treatment, the particular patient would have gone ahead with the treatment. See *Arndt v Smith*, [1997] 2 SCR 539, 148 DLR (4th) 48.

³⁰³ See *Sidaway v Bethlehem Royal Hospital Governors*, *supra* note 239.

³⁰⁴ The High Court of Australia, in *Rogers v Whittaker*, *supra* note 44, did not expressly make any statement on the standard of causation because there was no submission by counsel on it. However, the lower courts did consider and applied the subjective

The objective test adopted by the US and Canada treats the evidence of the patient about what he would have done as inherently biased, untruthful and tainted with bitterness and hindsight.³⁰⁵ On the other hand, the subjective test adopted by the UK and Australian courts “at least permits the plaintiff to attempt to persuade the court that she would have refused treatment if the risks had been disclosed.”³⁰⁶ However, in assessing the testimony of the patient, the UK courts do not outrightly dismiss the possibility of the testimony being self-serving. This way, they have modulated evaluation of the patient’s testimony by appealing to objective factors.³⁰⁷

In theory, the subjective test appears to be better suited to the doctrine of informed consent because it considers the particular plaintiff whose autonomy is at risk.³⁰⁸ Whether this is helpful to plaintiff patients is uncertain. This uncertainty is based on studies carried out by Gerald Robertson on informed consent cases since the decision in *Reibl v Hughes*, which identified causation as a major hurdle for plaintiffs³⁰⁹ and, which found that even though the test was increasingly subjective, plaintiffs still lose.³¹⁰

standard ordinarily applied in negligence. See *Rogers v Whitaker*, (1991) 23 NSWLR 600 at 618 and *Whitaker v Rogers*, (1990) Aust Torts Reports 81-462.

³⁰⁵ See *Reibl*, *supra* note 27 at 13.

³⁰⁶ Michael A Jones, “Informed Consent and Other Fairy Stories” [1999] Med L R 103 at 120.

³⁰⁷ See *Smith v Barking, Havering and Brentwood Health Authority*, [1994] 5 Med L R 285; *Gowton v Wolverhampton Health Authority*, [1994] 5 Med L R 432. The consideration of objective factors in assessing the patient’s testimony does not in itself detract from the subjective nature of the causal inquiry. Rather, it functions as an evidentiary test. See Klimchuk & Black, *supra* note 258 at 577.

³⁰⁸ King & Moulton, *supra* 224 at 444.

³⁰⁹ Robertson, Gerald, “Informed Consent in Canada: An Empirical Study” (1984) 22 Osgoode Hall LJ 139; Robertson, Gerald, “Informed Consent ten Years Later: The Impact of *Reibl v Hughes*” (1991) 70:3 Can Bar Rev 423.

³¹⁰ Gerald B Robertson, “Informed Consent 20 Years Later” [2003] Health L J special ed 153.

It is suggested that to overcome the hurdle posed by causation in an action in negligence, failure to disclose should be made actionable *per se* without a need to prove resulting harm;³¹¹ choice should be a legally protected interest;³¹² and, the onus on the plaintiff to prove causation should be shifted to the physician instead.³¹³ On this latter suggestion, the reasonableness of the plaintiff's position is presumed and the onus to rebut this presumption is placed on the physician.

3.5 Conclusion

This chapter sets the background for the rest of the thesis. It provides the lens through which informed consent in Nigeria will be analyzed. The major lessons of the chapter are that competence is not determined by status. Rather it is assessed based on the patient's ability to understand and appreciate the information that is necessary for a treatment decision, and to evaluate that information in terms of himself or herself. It describes how such an assessment may be made, perhaps, using a sliding scale, but preferably, functionally. Consent must proceed voluntarily from a competent patient. In this regard, fraud, duress, undue influence, misrepresentation and oppression may vitiate the consent that is given. In terms of disclosure, it finds that mere disclosure of information, however extensive, does not make a patient's decision informed unless the patient understands the information that has been disclosed. It suggests how understanding in a patient may be enhanced and determined. Accordingly, it suggests that an ideal disclosure standard is one which is determined by what the patient needs to make a decision. A successful claim for failure to obtain informed consent requires a causal link between the breach of duty to disclose and the injury suffered. This is a challenge for plaintiff patients. This challenge may be surmounted if choice is protected

³¹¹ Peppin, *supra* note 258 at 186.

³¹² See Marjorie Maguire Shultz, "From Informed Consent to Patient Choice: A New Protected Interest" (1985) 95 Yale LJ 219 at 232; Margaret A Berger & Aaron D Twerski, "Uncertainty and Informed Choice: Unmasking *Daubert*" (2005) 104 Mich L Rev 257.

³¹³ Peppin, *supra* note 258 at 186.

as an independent interest and breach of duty to disclose is made actionable *per se*. Alternatively, the truthfulness of a plaintiff patient's testimony about what he or she would have done should be presumed until the physician proves the contrary.

Chapter 4

Informed Consent in Nigeria: The Law and its Shortcomings

4.0 Introduction

The previous chapter provided a thorough and comparative analysis of the elements of informed consent. The analysis showed that an ideal informed consent must flow voluntarily from a patient who is found to be functionally capable, following disclosure of the information that the patient would need, and which the patient understands. As demonstrated below, although Nigerian law advocates the mainstream requirement for informed consent to treatment to protect autonomy, its requirement is equivocal. Hence its observation by physicians is arbitrary. The provisions of the law on the elements of informed consent, and the actual practice of informed consent, still defer to the traditional practice by which physicians act in the manner that they perceive to be in the best interest of patients. This chapter discusses Nigerian law on informed consent in light of the nature and standards of its elements as analyzed in Chapter Three.

The chapter begins with the law regulating the medical and dental profession in Nigeria. This legal exposition begins with the Nigerian constitution.³¹⁴ It analyses the relevant provisions in the *Constitution* which assure the privacy, dignitary and religious rights of Nigerians. It examines how these constitutional provisions have been interpreted by the Nigerian court, vis-à-vis, the *Code of Medical Ethics in Nigeria* [the *Code*]. Next, it sets out the relevant provisions of the *Code* dealing with informed consent. Further, it explores the actual practice of informed consent and how it relates to the *Code*. It finds that, although the right to personal dignity, liberty and privacy are constitutionally guaranteed, because of the arbitrariness in actual practice of informed consent, these

³¹⁴ *Constitution of the Federal Republic of Nigeria (Promulgation) 1999 No. 24 [the Constitution]*.

rights are not adequately respected. It finds that this arbitrariness, in part, derives from shortcomings in the *Code*. Consequently, the discussion highlights the shortcomings of the *Code* with suggestions on how to deal with the shortcomings.

4.1 Regulation of Medical Practice in Nigeria

The primary body which regulates medical practice in Nigeria is the Medical and Dental Council of Nigeria [the Council]. The Council is a statutory regulatory body set up by the *Medical and Dental Practitioners Act*.³¹⁵ Its objective is to regulate the practice of Medicine, Dentistry and Alternative Medicine in the most efficient manner that safeguards best healthcare delivery for Nigerians. One of its statutory functions is to prepare and review from time to time a statement as to the code of conduct which the Council considers desirable for the practice of the professions in Nigeria.³¹⁶ The Council is also empowered to establish the Medical and Dental Practitioners Investigating Panel and the Medical and Dental Practitioners Disciplinary Tribunal for the enforcement of its rules of conduct.

Pursuant to the enabling provision, the Council has prepared and reviewed editions of the rules of professional conduct of medical and dental practitioners in Nigeria. The latest edition of the rules is titled, “Code of Medical Ethics in Nigeria.”³¹⁷ This *Code*, alongside the Physician’s Oath Declaration (Declaration of Geneva) adopted by the World Medical Association in 1948 and amended in 1994,³¹⁸ and the International Code of Medical Ethics,³¹⁹ guide the ethical conduct of the medical and dental profession in Nigeria. The practices of the medical and dental practitioners are, however, subject to

³¹⁵ *Medical and Dental Practitioners Act* [cap M8] Laws of the Federal Republic of Nigeria 2004, s 1.

³¹⁶ *Medical and Dental Practitioners Act* [cap M8] Laws of the Federal Republic of Nigeria 2004, s 1(c)

³¹⁷ Medical and Dental Council of Nigeria, *Code of Medical Ethics in Nigeria* (Surulere: Petruvanni Co, 2004) [the “Code” or the “Code of Medical Ethics”].

³¹⁸ Set out in section 2(b) of the *Code*.

³¹⁹ Set out in section 8(a) of the *Code* (Declaration of Venice 1983).

the jurisdiction of the courts and to the overriding provisions of the Nigerian *Constitution*. Because of the overarching nature of the *Constitution*, and next to it, the courts, primacy is given to discussion about relevant provisions of the *Constitution*.

4.1.1 *The Nigerian Constitution*

The *Constitution* is the supreme law in Nigeria.³²⁰ Every other law in Nigeria derives validity from the *Constitution* and is invalid to the extent that it conflicts with the *Constitution*.³²¹ The *Constitution* sets out various fundamental rights of Nigerians, including: the right to life;³²² the right to personal dignity;³²³ the right to personal liberty;³²⁴ the right to privacy;³²⁵ and the right to freedom of thought, conscience and religion.³²⁶

By the provisions of the *Constitution*, every person has a right to life and no one shall, intentionally, be deprived of his or her life except in execution of the sentence of a court in Nigeria.³²⁷ This does not extend to where a person dies from the use of permissible force: to protect a life or property; to effect a lawful arrest or prevent a lawfully detained person from escaping; or to suppress a riot, insurrection or mutiny.³²⁸ Every person is entitled to respect for his or her personal dignity and, as such, must not be subjected to torture, inhuman or degrading treatment, held in slavery or forced into labour.³²⁹ The *Constitution* guarantees everyone the right to personal liberty. However, it makes exceptions where this right may be overridden. The exceptions include, in the

³²⁰ See the *Constitution*, s 1(1).

³²¹ The *Constitution*, s 1(3).

³²² The *Constitution*, s 33.

³²³ The *Constitution*, s 34.

³²⁴ The *Constitution*, s 35.

³²⁵ The *Constitution*, s 37.

³²⁶ The *Constitution*, s 38.

³²⁷ The *Constitution*, s 33(1).

³²⁸ The *Constitution*, s 33(2).

³²⁹ The *Constitution*, s 34(1).

case of a person who is under 18 years of age, limiting his or her liberty is allowed for the purpose of his or her welfare or education.³³⁰ For persons suffering from a communicable disease, unsoundness of mind, drug and alcohol addiction, and vagrants, they may be detained for purposes of their treatment, or to protect others.³³¹ Further, the *Constitution* assures everyone the privacy of their homes and communications.³³² It also gives every person the right to freedom of thought, conscience and religion, and to manifest and propagate the religion in teaching, worship, practice and observance.³³³

4.1.2 Case Law on Informed Consent

Although it may be argued that the foregoing rights can be interpreted to fit within the health care context, only the rights to life, privacy and religion have actually been engaged with by the court in the two known cases dealing with patient's refusal of treatment.³³⁴ The interpretation given to these rights as they concern medical treatment and informed consent are, arguably, extendable to bodily integrity, liberty and self-determination of patients. The first case, *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo [MDPDT v Okonkwo]*, reached the Supreme Court of Nigeria, the apex court in the country. The second case, *Esabunor v Faweya* is a Court of Appeal decision. The decisions in these cases are presented in turn.

³³⁰ The *Constitution*, s 35(1)(d).

³³¹ The *Constitution*, s 35(1)(e).

³³² The *Constitution*, s 37.

³³³ The *Constitution*, s 38.

³³⁴ Compare with *Constitution of the Republic of South Africa*, no 108 of 1996 as amended by *Constitution of South Africa Amendment Act*, no 3 of 1999 s 12(2) which provides that everyone has the right to bodily and psychological integrity which include the right- (a) To make decisions concerning reproduction; (b) To security in and control over their body; and (c) Not to be subjected to medical or scientific experiments without their informed consent.

4.1.2.1 *MDPDT v Okonkwo*

In *MDPDT v Okonkwo*,³³⁵ a patient who is a member of the Jehovah's Witnesses sect refused blood transfusion which was medically required for her ailment. She signed a card refusing blood transfusion, and indicating acceptance of non-blood products. She also released attending physicians from responsibility for the result of her refusal. The respondent physician proceeded to treat the patient without transfusing blood. However, the patient died. The physician was charged before the Medical Practitioners Disciplinary Tribunal and convicted on two counts of infamous conduct³³⁶ for attending to the patient in a negligent manner contrary to medical ethics and to his oath as a medical practitioner. On the first count, it was alleged that the physician knew that the patient was severely anemic, yet he failed to transfuse blood; he claimed to be inhibited from transfusing blood by the patient's refusal, yet he did not transfer the patient to a bigger hospital where such inhibition would not operate to the patient's disadvantage. On the second count, it was alleged that the physician allowed his own belief as a Jehovah's Witness to influence him into agreeing with the patient and her husband not to transfuse blood, and ignored the entreaties from the patient's relations.

Relying on the English case of *Sidaway v Board of Governor Bethlehem Royal Hospital*³³⁷ and the Canadian case of *Malette v Shulman*,³³⁸ the Supreme Court of Nigeria held that the combined effect of s 34 and s 35(1) of the 1979 *Constitution* now s 37 and 38 of the 1999 *Constitution* dealing with freedom of conscience and freedom of expression

³³⁵ *MDPDT v Okonkwo*, [2001] 7 NWLR (Pt 711) 206 (SCN).

³³⁶ In *Allinson v General Council of Medical Education and Registration*, [1984] 1 QB 750 infamous conduct was described as conduct regarded as disgraceful or dishonourable by medical professionals of good repute and competency. See also *Re: Idowu: A Legal Practitioner*, [1971] 7 NSCC 147, [1971] 1 All NLR 128.

³³⁷ *Sidaway v Board of Governor Bethlehem Royal Hospital*, *supra* note 239.

³³⁸ *Malette v Shulman*, *supra* note 30.

respectively was that an adult of sound mind has a right to choose what medical treatment offered to him he would accept or refuse. Ayoola JSC stated that:

The right to privacy implies a right to protect one's thought conscience or religious belief and practice from coercive and unjustified intrusion; and, one's body from unauthorized invasion. The right to freedom of thought, conscience and religion implies a right not to be prevented, without lawful justification, from choosing the course of one's life, fashioned on what one believes in, and a right not to be coerced into acting contrary to one's life, religious belief. ... The sum total of the rights of privacy and of freedom of thought, conscience or religion which an individual has, put in a nutshell, is that an individual should be left alone to choose a course for his life, unless a clear and compelling overriding state interest justifies the contrary.³³⁹

In his concurring judgment, Uwaifo, JSC added:

[U]nder normal circumstances no medical doctor can forcibly proceed to apply treatment to a patient of full age and sane faculty without the patient's consent, particularly if that treatment is of a radical nature such as surgery or blood transfusion. So, the doctor must ensure that there is a valid consent and that he does nothing that will amount to a trespass to the patient. Secondly, he must exercise a duty of care to advise and inform the patient of the risks involved in the contemplated treatment and the consequences of his refusal to give consent.³⁴⁰

The court noted that a consideration of a religious objection involves the balancing of several interests: the patient's constitutional right; state interest in public health, safety and welfare of society; and the interest of the medical profession in preserving its collective integrity. The court held that:

To give undue weight to one of these other interests over the rights of the competent adult patient may constitute a threat to liberty of the individual, unless legally recognized circumstances justify that weight should be ascribed to one over the others. ... Where, however, the direct consequence of a decision

³³⁹ *MDPDT v Okonkwo*, *supra* note 335.

³⁴⁰ *Ibid* at 255.

not to submit to medical treatment is limited to the competent adult patient alone, no injustice can be occasioned in giving individual right primacy.³⁴¹

The court held that any rule of ethics that does not consider individual circumstances may lead to unjust consequences.³⁴² It cited with approval, the statement made by Nzeako JCA that, “[e]verything put together, it does appear that the code of ethics which requires a medical practitioner to ‘always take measures that will lead to preservation of life’ failed to pin down on the conflict between the right of a patient to decide on what medical measures to agree to and the doctor’s code of ethics.”³⁴³

The court acknowledged that the decision of a competent patient to refuse treatment may be overridden on grounds of public interest or recognized interest of others, such as dependent minor children. However, the decision to override the patient’s refusal is for the court to make, not the physician.³⁴⁴ The physician who is faced with such refusal may “callously force” the patient out of the hospital, give refuge to the patient but without treating him, or take steps to ameliorate the consequences of the patient’s decision.³⁴⁵ Thus, the court upheld the conduct of the physician in respecting the patient’s decision to refuse treatment.

4.1.2.2 *Esabunor v Faweya*

In *Esabunor v Faweya*,³⁴⁶ the plaintiff, a Jehovah’s Witness, refused to consent to blood transfusion on her son who was about a month old and found to be suffering from a severe shortage of blood. The management of the hospital reported the matter to the police. The police applied for, and obtained an order authorizing treatment from a magistrate court. Pursuant to the order, the blood transfusion was carried out and the

³⁴¹ *Ibid* at 244.

³⁴² *Ibid*.

³⁴³ *Ibid* (emphasis in original).

³⁴⁴ *Ibid* at 245.

³⁴⁵ *Ibid*.

³⁴⁶ *Esabunor v Faweya*, [2008] 12 NWLR (pt 1102) 794.

child's condition stabilized. The plaintiff sought to quash the order of the magistrate court. She also claimed damages against the attending physician and the hospital for unlawfully transfusing blood into her son without consent and for denial of parental right. The plaintiff's claims were dismissed by the High Court. She appealed to the Court of Appeal.

In dismissing the appeal, the Court of Appeal referred to the constitutional right to life and held:

The Code of Ethics of the Medical Profession enjoins a [physician] not to allow anything including religion to intervene between him and his patient and that he must always take measures that lead to the preservation of life. This [C]ode of [E]thics places a great burden on medical practitioners in such a way that they cannot accede to the wish of a citizen who will allow a child to die on account of [religious] belief.³⁴⁷

The court also held that although the plaintiff had absolute right to choose a course for her life, her right does not extend to determining whether her son lives or dies on account of her religious belief.³⁴⁸

Next to the Constitution and case law, medical and dental professionals are regulated by the *Code of Medical Ethics*. The provisions of this *Code* vis-à-vis informed consent, and how the actual practice of informed consent is carried out, are explored below.

4.1.3 *The Code of Medical Ethics*

The key issues that are covered by the *Code* include:

³⁴⁷ *Ibid* at 810.

³⁴⁸ *Ibid* at 810.

- (i) general guidelines, including, general ethical principles of physicians, the rights and responsibilities of physicians, and informed consent;
- (ii) professional conduct;
- (iii) malpractice;
- (iv) improper relationship with colleagues or patients;
- (v) aspects of private medical or dental practice;
- (vi) self-advertisement and related offences; and
- (vii) conviction for criminal offences.

Based on relevance, particular focus is given to the first issue covered by the *Code*.

4.1.3.1 The *Code* on Informed Consent

Section 19 of the *Code* provides that physicians³⁴⁹ involved in procedures requiring the consent of the patient, the patient's relative, or appropriate public authority, must ensure that the appropriate consent is obtained before such procedures are carried out.³⁵⁰ As well, that explanations to patients from whom consent is sought should be simple, concise and unambiguous about expectations.³⁵¹ Further,

[w]here the patient is under age, (below eighteen years (18) by Nigerian law), or is unconscious, or is in a state of mind constituting a mental impairment, a next-of-kin should stand in. In the absence of a next-of-kin, the most senior doctor in the institution can give appropriate directive to preserve life. In special

³⁴⁹ This refers to medical and dental practitioners in Nigeria.

³⁵⁰ This suggests that there are medical procedures that do not require consent. Indeed, there are studies that found that consent is not sought in all cases of medical intervention, except where the risk is substantial as in surgery, or the patient is enlightened.

³⁵¹ This seems to accord with the discussion in Chapter Two that the nature of information that is to be provided for a valid consent is not extensive and that it suffices if only the name and general nature of the treatment is provided.

situations, a court order may need to be procured to enable life-saving procedures [to] be carried out.³⁵²

In cases which may involve surgical procedures that are difficult to reverse, such as sterilization, or removal of organs, such as amputation of limb, counseling sessions must be undertaken at a minimum of three (3) sittings to give the patient ample time to make an informed decision before a consent form is signed. The interval between counseling sessions must be, at least, four (4) weeks if the clinical situation permits. Discussion and explanation to the patient must be in the language the patient understands³⁵³ and when necessary, through a competent interpreter. In the course of counseling, the attendant benefits and risks of treatment must be clearly laid before the patient; appropriate professional advice on options must be given, and the preferred option is to be chosen by the patient who will then authorize the physician by completing a consent form.

4.1.3.2 The *Code* on Ethical Principles of Medical Practice

On ethical principles that guide medical practice in Nigeria, the *Code* provides that the primary goal of a physician is to promote the health of the patient, promote the general health of the community and respect the dignity of patients.³⁵⁴ While providing professional service to patients, physicians are given “absolute discretion and authority, free from unnecessary non-medical interference, in determining when to give their services, the nature of care to be given to a patient under their care and must accept responsibility for their actions.”³⁵⁵ For “special treatment procedures with determinable risks”, the physician is required to obtain the consent of the patient, a competent

³⁵² An example of such special case is where a Jehovah’s Witness refuses medically necessary blood transfusion on a child for religious reasons as in the case of *Esabunor v Faweya*, *supra* note 346.

³⁵³ The *National Health Bill* 2008 (SB. 50) [the *Bill*] section 23(2) requires that the patient’s literacy level be taken into account.

³⁵⁴ The *Code*, s 9(a).

³⁵⁵ The *Code*, s 9(h).

relative or another professional opinion before embarking on such procedures.³⁵⁶ However, for biomedical research involving human subjects, physicians are mandated to obtain the informed consent of the subjects.

4.1.3.3 The *Code* on the Rights and Responsibilities of Physicians

Section 10 of the *Code* provides that only physicians who are qualified according to the criteria set by the Council can practice as either medical or dental practitioners.³⁵⁷ One of the rights of physicians, according to the *Code*, is the right of absolute discretion in terms of patient treatment. According to the *Code*:

Subject only to accepted standards of care as determined by corporate professional opinion, a doctor must exercise absolute discretion and authority in determining the nature of care given by him including appropriate utilization of men [and] materials, money and time in order to achieve the best possible results for his patients. By the same token, he must accept the responsibility for the results obtained under his management. To this end, he must refrain from doing anything repugnant to his sense of honour or against his considered judgment, even in the face of unreasonable demand from the patient or other persons, whether individual or corporate.³⁵⁸

It further provides that where resources and facilities are inadequate or inappropriate, the physician must exercise ingenuity and initiative to secure the best treatment for the patient.³⁵⁹

³⁵⁶ The *Code*, s 9(m). “Special treatment procedures with determinable risks” does not have a specific definition in the *Code*. In the absence of a judicial interpretation, one can only speculate on what the phrase means. One such speculation is that it means where the treatment is untried, either generally or with respect to the particular use to which it is to be put. Provided that if it is purely a research project, without a treatment component, the ethical principles of research involving human subjects must be followed, and this includes obtaining informed consent of the subject.

³⁵⁷ The *Code*, s 10(a).

³⁵⁸ The *Code*, s 10(d).

³⁵⁹ The *Code*, s 10(e). However, the physician must not embark on treatment for which he or she does not have the requisite knowledge, competence or resources.

Apart from the *Code*, there is also a *National Health Bill 2008* [the *Bill*],³⁶⁰ which provides for, among other things, the rights, duties and responsibilities of physicians and patients. This *Bill* was passed by the Nigerian legislature in 2011. However, the *Bill* failed to receive presidential assent for it to come into force. With respect to informed consent, the *Bill* does not differ from the provisions in the *Code of Medical Ethics*. The relevance of the *Bill* to informed consent is that it sets out specific information a patient is entitled to receive. The information includes: the patient's diagnosis except where there is substantial evidence that disclosure would be contrary to the best interest of the patient;³⁶¹ the range of treatment options that are generally available to the patient;³⁶² the benefits, risks and costs associated with each option;³⁶³ and, the patient's right to refuse health services and the implications of such refusal.³⁶⁴

The *Bill* does not conflict with the *Code of Medical Ethics*. However, whereas the *Code* is silent, the *Bill* expressly recognizes the doctrine of therapeutic privilege, by which physicians may withhold information to benefit patients, and informed refusal by which physicians are to explain the implications to a patient who refuses treatment. By stating the information a patient is entitled to receive, the *Bill* seems to require informed

³⁶⁰ *National Health Bill 2008* (SB 50).

³⁶¹ *National Health Bill 2008* (SB 50) s 23(1)(a) This standard for withholding information from patient is very low and encourages paternalism. Where a patient's diagnosis is withheld from him, it seems that other information required to be disclosed would also be withheld. It is not clear, and the *Bill* does not state, who should authorize treatment in the circumstance. Significantly, while it appears that s 23 of the *Bill* is adapted from the *National Health Act, 2003* (Act No 61 of 2003) of South Africa, the South African legislation, in section 7, mandates that no treatment should be administered without patient's informed consent, and also provides for hierarchy of persons that can decide for a patient where the patient cannot decide himself, whereas, the *Bill* only stopped at providing for information that should be disclosed. In any case, this thesis leans towards the argument that where decision is made by persons other than the patient or his appointee, it is paternalistic.

³⁶² *National Health Bill 2008* (SB. 50) s 23(1)(b).

³⁶³ *Ibid* s 23(1)(c).

³⁶⁴ *Ibid* s 23(1)(d).

consent in all cases, although it does not state that treatment should not be administered without such consent. Since the *Bill* is not yet in force, limited reference will be made to it.

4.1.4 *Informed Consent in Practice*

Several studies have been carried out in order to evaluate the understanding and practice of informed consent in Nigeria. Some of these studies focus on patient experiences and evaluation of the consent process. Others focus on physicians' understanding, practice, and opinion about informed consent.

A 2009 study by David Irabor and Peter Omonzegele on the opinion and attitudes about the process of informed consent in Ibadan, Nigeria, found that the style of obtaining consent does not consider whether patients understand the proposed surgery - the organs involved, the repair contemplated, alternatives available and possible complications.³⁶⁵ The authors attributed it to illiteracy and the difficulty of translating certain surgical procedures in local languages. Further, the authors found that where "misunderstandings" arise post-operatively, the nature of the consent form used appears to protect physicians from liability.³⁶⁶ The approved consent form reads:

----- of ----- ... hereby, after detailed explanation of the advantages and disadvantages to me by Dr ----- willingly consent to the procedure of ---- on ... myself/child/spouse/mother/father/others... I affirm that I clearly understand the language of presentation. The option to think over the procedure for a period before assenting was also presented to me.

I further affirm:

(A) that the extent of the procedure and mode of [anesthesia] are left to the discretion of the physician.

³⁶⁵ Irabor & Omonzegele, *supra* note 10.

³⁶⁶ *Ibid* at 36.

(B) That any additional surgery or procedure to that described above will only be carried out if necessary and in my best interest and can be justified for medical reasons.³⁶⁷

The authors found that 63% of the participating physicians were satisfied with the consent form as it is. However, 58% thought it is too vague. Only 15.8% of the participants believe that patients know what they are signing for; only 10.5% obtain consent themselves; only 26.3% test patients' comprehension after consent has been taken by house-officers, and only 36.3% of the participants are certain that patients do not sign the consent form to avoid annoying the physician.³⁶⁸ A significant majority of the participants (68.4%) are of the opinion that the consent form is just a medico-legal document.³⁶⁹

One study by Osime *et al*³⁷⁰ carried out at the University of Benin Teaching Hospital (UBTH), Benin city, Nigeria, found that there was significant difference in the kind of information that is given to patients of different educational levels, especially in respect to the nature of operation, risks of operation and opportunity to ask questions.³⁷¹ It was also found that despite not being satisfied with the amount of information provided, or understanding the information, patients still consented to the medical procedure in order not to appear rude or have their operation cancelled.³⁷² Other complaints identified include the use of technical terms in the disclosure process, or the duty of disclosure of information being left to junior members of the surgical team who are not themselves fully knowledgeable about the risks of treatment.

³⁶⁷ Form MDCN/COMEIN/R19. See the *Code s 19*.

³⁶⁸ Irabor & Omonzegele, *supra* note 10 at 36. This implies that the remaining 63.7% of the physicians are not sure if patients sign the consent form just to please them.

³⁶⁹ *Ibid* 34 at 38.

³⁷⁰ OC Osime, O Okorie, F Osadolor & S Mohammed, "Current Practices and Medico-Legal Aspects of Pre-Operative Consent" (2004) 81:7 East African Medical Journal 331.

³⁷¹ Osime *et al*, *supra* note 9 at 334. See also LD Leffal, H Claude & J Organ, "Ethics in Research and Surgical Practice" (1997) 174 American J Surgery 589;

³⁷² Osime *et al*, *ibid*.

In another study by Temidayo Ogundiran and Clement Adebamowo³⁷³ on the opinions of surgeons in Nigeria about informed consent, it was acknowledged by a majority of the surgeons that enough information is not provided to patients before taking their consent.³⁷⁴ Informed consent was largely perceived as a medico-legal ritual rather than a moral obligation. It was generally acknowledged that informed consent was not a truly participatory decision making process. Very significantly, a majority of the surgeons see informed consent as alien to the African psyche,³⁷⁵ and equate its importance to signing a consent form.³⁷⁶ Opinions were, however, closely divided on whether informed consent can be sought for every procedure.

In terms of information usually disclosed, it is helpful to set out the frequency at which particular information is disclosed. They include: (i) therapeutic options, including surgical operation (38.2%); (ii) special procedures to prevent or reduce risks (36.3%); (iii) detailed explanation of diagnosis (31.4%); (iv) available alternative surgical procedures (29.4%); (v) specific operative details (23.5%); (vi) risks associated with chosen operation (22.5%); (vii) potential benefits of the operation (19.6%); (viii) specific information about anesthesia and immediate postoperative period (19.6%); (ix) frequency of occurrence of major operative risks (18.6%); and (x) the likely surgeon to perform the operation (4.9%).³⁷⁷

Ogundiran and Adebamowo also found that surgeons seldom encounter patients who refuse to consent to surgical procedures. In the limited instances where patients refuse surgery, the surgeons agree that poor communication between the surgeon and the patient is a cause. Where patients decline to consent to proposed surgical operation, a

³⁷³ Ogundiran & Adebamowo, *supra* note 9.

³⁷⁴ *Ibid* at 742.

³⁷⁵ Although a large majority agreed that insisting on informed consent does not amount to being insensitive to the African culture.

³⁷⁶ Ogundiran & Adebamowo, *supra* note 9 at 742.

³⁷⁷ *Ibid* at 743.

significant majority of the surgeons³⁷⁸ indicate that they are most likely to threaten the patient.³⁷⁹

4.2 Analysis of Informed Consent in Nigeria: Law and Practice

4.2.1 *The Constitution*

Although not expressly stated, the right to bodily integrity and liberty protected by informed consent process are discernible within the constitutional provisions, as interpreted by the court. The protection from unauthorized invasion which the court held to refer to the right to privacy ensures that the bodily integrity of the patient is not violated. Similarly, while protection from coercion or denial of the right to choose the course of one's life may refer to the constitutional right to freedom of thought and religion, it also extends to the liberty interests of patients and their right to be self-determining. This means that, following the interpretation by the court, the right to personal dignity is not limited to torture, inhuman or degrading treatment, but includes unlawful and non-consensual invasion of the body of an individual. Besides, it is arguable that, except where justification exists, to impose treatment on a competent patient without his or her consent, or despite his or her refusal, is to subject the patient to inhuman or degrading treatment which is clearly proscribed by the *Constitution*.

It seems that the personal liberty guaranteed by section 35 of the *Constitution* is the liberty of movement. That is, the right against unjustified physical restraint or

³⁷⁸ That is 89% of the surgeons.

³⁷⁹ Ogundiran & Adebamowo, *supra* note 9 at 743. This may seem shocking. However, the court in *MDPDT v Okonkwo* noted that what a physician does, following a refusal of treatment, is entirely up to him. But, he or she must not impose treatment on the patient. See *MDPDT v Okonkwo*, *supra* note 335 at 245. The court suggested that the physician may callously force the patient out of the hospital. Thus, it would seem that a physician may rightfully threaten a patient who has refused treatment. The problem with this is that where, following the threat, the patient accepts treatment, the voluntariness of the decision is suspect.

confinement. This is, arguably, the sense in which it is understood.³⁸⁰ Whether it can be extended to liberty to determine what happens to a person's body in the healthcare context is not clear. However, the Supreme Court's statement that an individual should be left alone to determine the course of his or her life, and that it is the role of law to ensure the fullness of liberty where there is no threat to the society,³⁸¹ is a clear statement in favour of personal liberty. The implication is that reliance can be placed on sections 34, 35, 37 and 38 of the *Constitution* to demand the right to participate in medical decision making. On this basis, it is submitted that the right to informed consent is a constitutionally protected right.

On the other hand, it would also appear that a person who is below the age of 18 years may be involuntarily confined, without injuring his or her liberty rights, provided the purpose is for his or her education or welfare.³⁸² Similarly, persons suffering from infectious or contagious disease, or who are of unsound mind, or addicted to drugs or alcohol or who are vagrants, may be detained for the purpose of their care or treatment or the protection of the community.³⁸³ The *Constitution* is however silent on whether, having deprived these persons of their freedom of movement, their consent has to be obtained before care is given or treatment administered on them. These issues are important because, if treatment may be imposed without their consent, particularly where the capacity to understand and appreciate the nature and implication of any decision made exists, the purpose of informed consent, as it pertains to these persons, is, arguably, negated.³⁸⁴

³⁸⁰ See for example Jadesola O Lokulo-Sodipe, "An Examination of the Legal Rights of Surgical Patients under the Nigerian Laws" (2009) 1:4 *Journal of Law and Conflict Resolution* 79 at 82.

³⁸¹ *MDPDT v Okonkwo*, *supra* note 335 at 244.

³⁸² The *Constitution*, s 35(1)(d).

³⁸³ The *Constitution*, s 35(1)(e).

³⁸⁴ There is as-yet, no comprehensive mental health legislation in Nigeria. In 2003, a bill was introduced to the Nigerian legislature. The purpose of this bill was to repeal the existing *Lunacy Act* of 1958, a colonial law, and to replace it with a Mental Health Act for Nigeria. Whereas the Lunacy Act does not provide for those confined to be treated,

Perhaps this explains why the *Code* automatically deems mental impairment and being below the age of 18 years, as evidence of incompetence. Consequently, it would seem that, in regards to these persons, the erosion of their fundamental rights of liberty and personal dignity, which are the interests compromised by involuntary confinement and treatment without consent, respectively, are validated by the *Constitution*.

4.2.2 Case Law

The Supreme Court in *MDPDT v Okonkwo* clearly (and strongly) endorsed and upheld the rights of patients to determine the treatment they want to receive and to be given information that is necessary for that purpose. It hinged this on the constitutional right to privacy and freedom of thought and religion. By this decision, the court elevated patient autonomy over the beneficence of physicians and made informed consent a clear part of Nigerian law. It recognized that although ethical principles of medical practice require physicians to preserve life, where such principles conflict with an adult patient's right of self-determination, they must be subject to the right of self-determination. This is except where the court overrides the decision made, in the interest of public health or other recognized interests, for example, the interest of dependent minors. However, the court's suggestion that a physician may callously force a patient who refuses consent out of the hospital leaves open the question whether if, following such callousness, the patient reconsiders and accepts treatment, such consent is voluntary.

among the provisions of the bill was confinement for purposes of treatment and the requirement of consent before treatment. The bill failed to receive sufficient support and, consequently, it was withdrawn. See Andrew Hudson Westbrook, "Mental Health Legislation and Involuntary Commitment in Nigeria: A Call for Reform" (2011) 10 Washington University Global Studies Law Review 397; World Health Organization, "WHO-AIMS Report on Mental Health System in Nigeria" a Report of the assessment of the mental health system in Nigeria using the World Health Organisation - Assessment Instrument for Mental Health Systems (WHO-AIMS) Ibadan Nigeria 2006.

The decision of the Court of Appeal in *Esabunor v Faweya* which referred to the physician's ethical duty to preserve life, and the constitutional right to life as the basis for dismissing the appeal of the plaintiff, suggests that, except where the patient is an adult and of sound mind, and has made a contrary decision, the physician's ethical duty to protect the life and promote the health of the patient is paramount. Arguably, the Court in *Esabunor v Faweya* would have reached the same outcome on the basis of its inherent *parens patriae* jurisdiction over children without basing its decision on the physician's ethical duty to save life.

4.2.3 *Code of Medical Ethics*

The provisions of the *Code* appear to balance physician beneficence and patient autonomy. The *Code* charges physicians with the obligation of protecting both the health and life of the patient, and his or her dignity. It ensures that physicians exercise the discretion conferred on them scrupulously by making them responsible for the outcome of the exercise of discretion. In respect of patient dignity, the *Code* makes provisions for the consent of patients to be obtained.

On a literal construction of the *Code's* provisions, two possible interpretations arise: first, it appears that consent is not required for every medical procedure. The *Code* seems to qualify its requirement of consent with words which imply that it is not always required. For example, the *Code* enjoins physicians to obtain the consent of patients in "procedures requiring the consent of the patient, his relation or appropriate authority."³⁸⁵ Such procedures would include where the treatment is "special" and has "determinable risks."³⁸⁶ These terms are not defined by the *Code*. In the absence of judicial guidance, they are subject to various interpretations. For example, they may refer to new treatments, or to a new way of applying an existing form of treatment, or to treatments which have a research component. However, even for special treatments

³⁸⁵ The *Code* s 19. First paragraph.

³⁸⁶ The *Code* s 9(m).

with determinable risks, the *Code* suggests that getting another professional opinion may suffice to authorize the procedure.³⁸⁷ That consent of the patient is not always required is further buttressed by the *Code's* definition of professional negligence to include a "failure to obtain the consent of the patient (informed or otherwise) before proceeding on any surgical procedure or course of treatment, *when such a consent was necessary.*"³⁸⁸

Second, the use of words like, "consent" and "informed consent", suggests that the *Code* provides for what may be described as a gradation of consent, with the spectrum running between procedures which require no consent at all, through procedures requiring mere consent, to procedures requiring informed consent. As indicated in Chapter Two, consent and informed consent do not necessarily mean the same thing. With respect to procedures which require mere consent, the *Code* requires explanations about expectations to be concise and unambiguous. Where informed consent is required, several counseling sessions, must be scheduled at decent intervals, at which the benefits, risks and treatment alternatives must be presented to the patient. Informed consent is required for difficult and irreversible procedures.³⁸⁹ In other words, the *Code* sets a higher standard where the treatment involves procedures that are difficult to reverse such as sterilization or amputation, and a lesser standard for special treatments with determinable risks.³⁹⁰ This appears to be intentional. For example, in section 28, the *Code* provides that it is professional negligence for a physician to fail to obtain the "consent of the patient (*informed or otherwise*)" before administering treatment.³⁹¹ However, what may be distilled from modern jurisprudence on informed consent in Western countries is that consent is required for every medical treatment

³⁸⁷ Perhaps a second professional opinion is required only where the patient is incompetent and a competent relative is not available. It is, however, not clear if the *Code* intends this.

³⁸⁸ The *Code* s 28(e) (emphasis in original. Italics added.)

³⁸⁹ See the *Code*, s 19.

³⁹⁰ See also the *Code*, s 28(e).

³⁹¹ Italics added.

except where this is impossible, as in emergency situations, or, pursuant to certain legislative instruments (e.g. public health legislation), consent is unnecessary.³⁹² And consent must be informed.³⁹³

Where consent (including informed consent) is sought, the *Code* intends that the consent process be initiated in the language and manner in which the patient will understand. This implies that the physician is required to speak the language of the patient or have the information translated into his or her language. As far as is practicable, the physician must also simplify the information in such a way that the patient, whatever his or her level of literacy, may understand. This requirement acknowledges the challenges posed by the multiplicity of languages and the low literacy level in Nigeria which, while extending the cost of obtaining informed consent in terms of time and effort, does not justify ignoring it altogether.

With respect to the requirements for informed consent, allowing a decent interval between one counseling session and the next, affords a patient ample time, where the clinical situation permits, to reflect on the procedure and to come to a reasoned and unhurried decision. Further, the requirement of professional advice on the options ensures that the physician does not simply recite the required information to the patient and leaves him or her to make his or her decision. The professional advice may invite further questioning or discussion between the physician and the patient where the option recommended by the physician is not one which the patient favours. Thus, it facilitates a collaborative decision making process. Following these disclosures and the physician's professional advice on the options available, or in the case of mere consent, the concise explanation about expectations, the preferred option is to be chosen by the patient who authorizes the procedure by signing the consent form.³⁹⁴

³⁹² See Chapter Two.

³⁹³ See Chapter Two.

³⁹⁴ The *Code*, s 19.

4.2.4 *Actual Practice*

The practice of informed consent is arbitrary. This arbitrariness stems, partly, from the provisions of the *Code*, and partly from the physicians themselves. Although the *Code* regulates the conduct of physicians, its provisions, arguably, only set the minimum standard of conduct that is expected. As argued above, the right of patients to determine the treatment they receive and to have information necessary to that effect is embedded within the constitutional rights of personal dignity, liberty, privacy and freedom of thought and religion. As a constitutionally protected right, it deserves respect even if the *Code* did not provide for it. Although obtaining informed consent in Nigeria may be challenging as noted in Chapter Five, the challenges do not, altogether, excuse the arbitrariness of the practice of informed consent. They only make the consent process more exacting.

Yet the *Code* contributes to the unsatisfactory practice of informed consent in Nigeria even though physicians are also complicit in it. The nature of disclosure that is made, whether consent is sought at all, and the emphasis that is placed on the consent form which, in itself, does not adequately reflect the consent process, may align with the interpretation of the *Code* and, to an extent, be blamed on the *Code*. The format for the consent form provided by the *Code* is vague, a fact acknowledged by physicians in the study by Irabor and Omonzegele, yet a majority of the physicians are satisfied with it.³⁹⁵ The form does not reflect the participatory consent process. It permits a physician to carry out any further surgery other than the one consented to if the physician thinks it is necessary, in the best interest of the patient. Yet, the *Code* intends it to be the only valid form that may be used to obtain consent. Arguably, this protects a physician from liability in battery for exceeding the scope of consent, or for performing a procedure other than the one to which consent has been given, provided the physician can justify the procedure as being medically necessary, and in the best interests of the patient.

³⁹⁵ Irabor & Omonzegele, *supra* note 10 at 36.

Perhaps, this explains why the consent form, which is supposed to embody the consent process, is seen as a medico-legal requirement that protects physicians from liability.³⁹⁶

Further, as argued above, in compliance with the *Code* which, arguably, does not demand consent in all cases, consent is not always sought before treatment.³⁹⁷ Sometimes, the nature of disclosure is such as satisfies the requirement of mere consent.³⁹⁸ Ogundiran and Adebamowo find that physicians are almost evenly split on whether informed consent should be sought in all cases.³⁹⁹

Lastly, given the judicial backing afforded by *MDPDT v Okonkwo* to the effect that physicians may callously force out from the hospital, a patient who refuses treatment, it does not seem surprising that in the few cases when patients exercise their right of self-determination to refuse treatment, surgeons are more likely to threaten them.⁴⁰⁰ Consequently, it appears that the shortcomings or dissatisfaction with the way informed consent is practiced may be traced particularly to defects in the *Code*. Some specific shortcomings of the *Code* are highlighted below.

However, the *Code* is not entirely to blame. The *Code* does not require physicians to be selective in their duty to disclose based on the literacy level of patients. The *Code* also does not provide that physicians may threaten patients who refuse treatment. As stated before, physicians are subject to the overriding provisions of the *Constitution* and the court. The *Constitution* provides, and the court has interpreted, at least, the right to privacy and freedom of thought and religion as embodying the concept of informed consent. The Supreme Court, per Uwaifo JSC expressly stated that the physician must ensure that there is a valid consent and that he or she must exercise a duty of care to advise and inform the patient of the risks involved in the contemplated treatment and

³⁹⁶ See Ogundiran & Adebamowo, *supra* note 9 at 742.

³⁹⁷ See Osime *et al*, *supra* note 9.

³⁹⁸ See generally Ogundiran & Adebamowo, *supra* note 9.

³⁹⁹ *Ibid* at 742.

⁴⁰⁰ *Ibid* at 743.

the consequences of his or her refusal to give consent.⁴⁰¹ Consequently, even if the provisions of the *Code* are not optimum, the Supreme Court decision in *MDPDT v Okonkwo* provides sufficient direction on what physicians are required to do.

4.3 Specific Shortcomings of the *Code of Medical Ethics in Nigeria*

4.3.1 *Assumption of Patient's Decisional Authority*

A major shortcoming of the *Code* on informed consent is its assumption that, by stating that the preferred option is to be chosen by the patient, it has effectively placed decisional authority in his or her hands.⁴⁰² As highlighted above, the *Code* provides that the patient should make the decision. Yet, one of the ethical principles of medical practice, which is also a right accorded to physicians, is their absolute discretion to determine the nature of treatment to give to a patient who is in their care. This raises two possible interpretations: on the one hand, it may be argued that to “determine the nature of treatment to give” refers to the right of a physician to decide what treatment he or she is willing to render to patients and when. Physicians are also autonomous persons who, as the *Code* provides, are at liberty to choose whom they will offer their professional services to, except in an emergency.⁴⁰³ As such, it may be argued that

⁴⁰¹ *MDPDT v Okonkwo*, *supra* note 335 at 255.

⁴⁰² Although the Supreme Court in *MDPDT v Okonkwo* certainly placed authority on the patient and away from the physician. However, the court acknowledged the conflict in the *Code* between the ethical principles and rights of the physician and the autonomy of patients. See *MDPDT v Okonkwo*, *supra* note 335 at 244.

⁴⁰³ The *Code* s 9(g). In deciding whom to treat, physicians must be mindful not to discriminate against certain patients. Although a physician may not be compelled to render professional services which he or she conscientiously objects to, how he or she goes about it must not offend the constitutional right of freedom from discrimination. See the *Constitution* s 42. *Prima facie*, this right is only triggered by executive or administrative actions of government which discriminate against a person on grounds of ethnic affiliation, sex, religion or political opinion. However, since the *Code of Medical Ethics* was developed pursuant to executive powers conferred by the Nigerian legislature, it is a product of an executive action. Besides, the *Constitution* also contemplates that the practical application of any law in force in Nigeria must not be discriminatory. See the *Constitution* s 42(1)(a). A patient who feels that he or she has

physicians have absolute discretion to determine what treatment options they are willing to provide, and having laid out these options and their risks, the patient decides. On this view, there is no conflict in the *Code*.

On the other hand, to “determine the nature of care to be given to a patient under their care”⁴⁰⁴ may mean that it is within the absolute discretion of physicians to determine the treatment a patient in their care receives. This view embodies a contradiction in the *Code*, or indicates conflicting desires. It means that at one and the same time, the *Code* attempts to give decisional authority to patients, in protection of the right of self-determination, and to maintain the traditional authority of physicians to decide the treatment a patient receives. It also means that the *Code* acknowledges both the desirability of patient autonomy and the professional obligation of the physician to always act according to his or her considered judgment of what is in the interest of the patient. In other words, on this latter view, the *Code* bestrides two models of patient-physician relationship identified as “patient sovereignty” and “medical paternalism.”

Medical paternalism, also referred to as the Hippocratic tradition, is based on a view of the physician as the dominant, authoritarian figure whose expertise and training places him or her in a position to be able to make decisions in the best medical interests of the patient. On the other hand, patient sovereignty aims to take this authority from the physician and to place it in the patient so that the patient, not the physician, would control the decision about what treatment to receive. While a blending of the two may be achieved,⁴⁰⁵ simultaneously locating decisional authority in the physician and in the patient indicates a conflict: who decides? There are justifications for either the patient or the physician making the decisions. These justifications are explored next.

been discriminated against may seek redress from the High Court of the State where the discrimination occurred. See the *Constitution* s 46(1).

⁴⁰⁴ The *Code* s 9(h).

⁴⁰⁵ It is argued that the *Code*, to an extent, contemplates such blending.

4.3.1.1 Decision-Making by Physicians: Justifying Paternalism in Nigerian Healthcare

If being treated paternalistically means a simulation of the relationship between a child and her parents in which parents decide what is best for the child rather than let the child decide what is best for him or her, then that appellation is not the exclusive preserve of physicians. Rather, it extends to anybody who purports to act in the best interest of another. As Patricia Peppin observes, participation of patients in their treatment decision provides them with an opportunity to exercise choice according to their own values and beliefs rather than through a “paternalistic imposition of another’s treatment decisions.”⁴⁰⁶ In *Malette v Shulman*, Robins JA for the Ontario Court of Appeal expressed the self-determining principle of informed consent thus:

The doctrine of informed consent has developed in the law as the primary means of protecting a patient’s right to control his or her medical treatment. ... the doctrine of informed consent is plainly intended to ensure the freedom of individuals to make choices concerning their medical care. For this freedom to be meaningful, people must have the right to make choices that accord with their own values, regardless of how unwise or foolish those choices may appear to others.⁴⁰⁷

Self-determination is like a shield which protects an individual from outside control, and manifests the wish to be an instrument of one’s own and “not of other men’s acts of will.”⁴⁰⁸ The interpretation of “other men” seems to generally refer to physicians. If paternalism is strictly construed to mean “overriding” a patient’s decision in order to benefit him or her,⁴⁰⁹ then a physician who does this has clearly undermined the patient’s decision. An example of a situation giving rise to this would be where a patient

⁴⁰⁶ Peppin, *supra* note 258.

⁴⁰⁷ *Malette v Shulman*, *supra* note 30.

⁴⁰⁸ Isaiah Berlin, “Two Concepts of Liberty”, in *Four Essays on Liberty* (Oxford: Clarendon Press, 1969) at 118;

⁴⁰⁹ See Beauchamp & Childress, *supra* note 5 at 274 (paternalism was defined as the intentional overriding of a person’s known preferences or actions by another person, justified by reasons referring solely to benefitting or avoiding harm to the person whose will is overridden).

expressed a preference for a particular treatment X, and the physician thinks X carries more risk than treatment Y, and goes ahead and carries out treatment Y which has a lesser risk. According to Beauchamp and Childress, “Paternalism always involves some form of interference with or refusal to conform to another person’s preferences regarding their own good. Paternalistic acts typically involve force or coercion, on the one hand, or deception, lying, manipulation of information, or nondisclosure of information on the other.”⁴¹⁰

Essentially, a physician will be acting paternalistically where he or she fails to carry out his or her duty of disclosure. This contemplates where the physician withholds information, such as the patient’s diagnosis, out of concern not to cause him or her undue anxiety. It may also include where the physician actively lies or deceives the patient, perhaps by trivializing his or her medical condition, or manipulates the information in a way that ensures that the patient’s decision aligns with the physician’s preference. It is also paternalistic for a physician to make healthcare decisions for a competent patient rather than let the patient make it (as distinct from overriding an already made choice).⁴¹¹

In the foregoing examples, the intention of the physician is to further the patient’s interest, or protect his or her welfare. Because the patient is competent to determine what is in his or her interest, such paternalism is offensive. In Kantian liberalism, the moral fundamentality of individual autonomy seems to prohibit any paternalistic actions when the individual involved is capable of self-governance.⁴¹² On this view, it would always be morally wrong for the physician to withhold information from a competent patient on the grounds that such information is not in the patient’s interest to receive as it may create undue anxiety. Withholding such information is akin to treating the

⁴¹⁰ *Ibid.*

⁴¹¹ See generally Thomas A Mappes & David DeGrazia, *Biomedical Ethics* 4th ed (New York: McGraw-Hill, Inc, 1996) at 30-33; Beauchamp & Childress, *supra* note 5 at 273-274.

⁴¹² Mappes & DeGrazia, *ibid* at 31.

patient as a means to an end, even if the end is his or her restored health.⁴¹³ John Stuart Mill captured the unpopularity of paternalistic action in his classical utilitarian statement. According to him:

The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not sufficient. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinion of others, to do so would be wise, or even right.⁴¹⁴

This is certainly true where the patient is competent. What about cases where the patient is found to be incapable of deciding? Where the patient appointed some other person to decide on his or her behalf, a decision made by the patient's appointee is an exercise of self-determination. Where this is not the case, it is arguable that decision will have to be made on the patient's behalf by a substitute decision maker, and the substitute decision maker will be acting in what he or she perceives to be in the best interest of the patient. This is still paternalism. But, because the patient is incapable of deciding for himself or herself, such paternalism is justified.⁴¹⁵ Mappes and DeGrazia caution that in considering the justifiability of paternalistic actions, the difference between paternalism as a principle, and extreme paternalism, should be borne in mind.⁴¹⁶ This difference lies in the motive for the paternalistic intervention. According to them, if the intent is to benefit the individual, it is extreme paternalism. If, on the other hand the intent is to keep the individual from harm, it is paternalism as a principle, and is justified.⁴¹⁷ An example of the latter will be intervention in an emergency to save the life of the patient, or to keep him or her from getting worse.

⁴¹³ See Charles Fried, *Medical Experimentation: Personal Integrity and Social Policy* (New York: American Elsevier, 1974) at 101.

⁴¹⁴ Mill, *supra* note 4 at 135.

⁴¹⁵ Beauchamp & Childress, *supra* note 5 at 273.

⁴¹⁶ Mappes & DeGrazia, *supra* note 411 at 31.

⁴¹⁷ *Ibid.*

Mappes and DeGrazia's distinction does not fully account for decision making in situations, other than emergencies, where a patient is incompetent. In such situations, keeping the patient from harm may not arise. Rather, the decision made may be one that is assumed to be beneficial to the patient. Besides, it is for the benefit of the patient that he or she should be kept from harm. Thus, Mappes and DeGrazia's distinction is, arguably, without a difference. If any distinction at all is to be made, such distinction should be between justified and unjustified paternalism: justified, where the patient is incompetent and has not authorized another person; unjustified when the patient is capable of deciding for himself or herself or has appointed somebody else. Even Mill qualified his rejection of paternalism in the case of minors and incompetent persons like mentally impaired persons. Mill states:

[This] doctrine is meant to apply only to human beings in the maturity of their faculties. We are not speaking of children, or of young persons below the age which the law may fix as that of manhood or womanhood. Those who are still in a state to require being taken care of by others, must be protected against their own actions as well as external injury.⁴¹⁸

However, Mappes and DeGrazia argue that though it may seem like an endorsement of paternalism in the case of minors and mentally impaired persons, Mill's qualification only removes the limitation of coercion in terms of autonomy as liberty of action, and narrows the choices available in terms of autonomy as freedom of choice. However, they argue, it does not limit autonomy in the sense central to both Mill and Kant's moral position. This is because, according to them, those with diminished autonomy like minors and the mentally impaired, lack what is essential for an appropriate level of effective rational deliberation.⁴¹⁹ The validity of this interpretation is not certain. A literal construction of Mill's statement suggests that the idea of individual liberty applies to persons who are competent. For persons who, by reason of age or mental state, require care from others, they must be protected from their own actions, which benefits

⁴¹⁸ Mill, *supra* note 4 at 135.

⁴¹⁹ Mappes & DeGrazia, *supra* note 411 at 32.

them, as well as from external injury, which keeps them from harm. Even by Mappes and DeGrazia's distinction, the foregoing is paternalism.

If this argument is correct, it would mean that where a patient possesses diminished autonomy,⁴²⁰ it may be justified to treat him or her paternalistically. In other words, the lesser the level of autonomy that a patient is capable of exercise, the greater the paternalism that is required. To express it mathematically, the level of paternalism that is justified is inversely proportional to the level of autonomy that can be exercised.

Paternalism may be justified where the pain and distress from illness and disease are so severe as to make a patient's competence impaired.⁴²¹ As argued in Chapter Three, accidents, illnesses, diseases, and emotional pressures may diminish patients' rational capacities and consequently their autonomy.⁴²² Where this is the case, it may be justifiable to treat the patient paternalistically.

It is argued that pursuing informed consent may actually work against the interests of the patient by robbing him or her of the therapeutic powers of faith that a medical intervention will be successful. For example, Jay Katz notes that disclosure and consent may be deleterious to a patient in those situations where, as a result of the ubiquitous uncertainties of medicine about risks and benefits, the unexamined faith of both the physician and the patient in the curative power of medical interventions, contributes significantly to therapeutic success.⁴²³ According to him, even partial awareness of such uncertainties which informed consent would bring to the fore, could prove detrimental to recovery.⁴²⁴ However, as argued in Chapter Three, the fears expressed about the

⁴²⁰ "Diminished autonomy" is used to describe persons who are unable to decide for themselves.

⁴²¹ See Chapter Two. See also Manson & O'Neill, *supra* note 52 at 5. A finding of incompetence justifies paternalism which this paper defines as decision making by persons other than the patient, in the interest of the patient.

⁴²² Mappes & DeGrazia, *supra* note 411) at 34.

⁴²³ Katz, *supra* note 43 at 140.

⁴²⁴ *Ibid* at 141.

consequence of disclosure for the purpose of informed consent, often do not materialize, and studies have shown that patients benefit from being informed.⁴²⁵

Why does paternalism have to be justified at all if it is for the benefit of the patient? Again, the argument traces back to the American repudiation of any form of authority and class difference. On this view, the growing awareness of class differences in society, and the fact that those who perform paternalistic acts, for example, physicians, are usually members of the upper-middle class, while those who are treated paternalistically are usually, though not necessarily, members of the poorer, less privileged class, may be enough reason to repudiate paternalism.⁴²⁶ Further, the differences in the values and preferences between members of each of the classes lead to serious doubt about the capacity of physicians to act in the best interests of the patient. Therefore, while it may not be morally wrong for the best interest of a patient to be pursued, there is a possibility that leaving the decision about what that best interest is, to persons other than the patient or his or her appointee, may lead to abuse. According to Mappes and DeGrazia,

[I]t is not the moral legitimacy of the principle of autonomy that is really at issue when paternalistic acts are increasingly rejected. Rather, what is at issue are the abuses resulting from so-called paternalistic acts that do not in fact serve to benefit (or keep from harm) the individuals constrained but do serve the ends of the members of the profession wielding paternalistic authority.⁴²⁷

The foregoing argument purports that physicians who make treatment decisions for competent patients may not really serve the ends of the patients. This may occur in a number of ways. An example is where the physician is conflicted, such as where the physician recommends treatment for a medical condition which the patient does not have, just for the purpose of the financial reward. It is best to allow patients to determine their own best interests in order to avoid the danger of tyranny. For, unless

⁴²⁵ See Chapter Three.

⁴²⁶ Mappes & DeGrazia, *supra* note 411 at 35.

⁴²⁷ *ibid.*

the interests and values of both the physician and the patient coincide, the patient's best interest, where he or she is competent, is better served if paternalism is rejected rather than accepted.

4.3.1.2 Decision-Making by Patients: Autonomy in Nigerian Health Care

Under a free government at least, the free citizen's first and greatest right, which underlies all others - the right to himself - is the subject of universal acquiescence, and this right necessarily forbids a physician or surgeon, however skillful or eminent, to violate without permission the bodily integrity of his patient...and [operate] on him without his consent or knowledge.⁴²⁸

Justice Cardozo aptly captures the importance of autonomy in his often quoted dictum "Every human being of adult years and sound mind has a right to determine what shall be done with his own body."⁴²⁹

The foregoing demonstrates that decision making is to be made by the patient in the exercise of his or her right to be self-determining. It is argued that other ethical principles, such as beneficence, justice, and non-maleficence, presuppose and can be reduced to respect for autonomy.⁴³⁰ According to Raanan Gillon, beneficence and non-maleficence toward autonomous moral agents presuppose respect for the autonomy of these agents even when they exercise such autonomy to refuse medical interventions which are life-saving. For justice, Gillon argues that justly responding to people's needs will require respect for those people's autonomous decisions even when such decisions would result in death or grievous bodily harm. Justice in this case would question expending scarce resources on a person who voluntarily decided he or she does not want it. Gillon concludes that respect for autonomy builds in a prima facie moral requirement to respect both individual and cultural moral variability.

⁴²⁸ *Pratt v Davis*, 118 Ill App 161 at 166 (1905).

⁴²⁹ *Schloendorff v The Society of the New York Hospital*, *supra* note 25 at 129-30.

⁴³⁰ See Raanan Gillon, "Ethics Needs Principles – Four can Encompass the Rest – and Respect for Autonomy should be "First Among Equals" (2003) 29 *Journal of Medical Ethics* 307.

The primary contribution of autonomy is that it provides a basis for a right to refuse treatment.⁴³¹ In other words, autonomy in health care is a negative right which the holder can only exercise in refusing treatment; it cannot be used to compel a particular treatment.⁴³² Its practical significance to a physician is that it shifts responsibility for decision making to the patient, affords protection from liability from malpractice suits, and enables the physician to fulfill his or her ethical duty of respecting the dignity of patients.⁴³³ As seen from the provisions of the *Code*, physicians have absolute discretion to determine what treatment to give on the condition that they bear the responsibility for the outcome of the treatment. Thus where the decision making authority is shifted to patients, it arguably relieves physicians of responsibility for the outcome of treatment. By the decision in *MDPDT v Okonkwo*,⁴³⁴ the Supreme Court indicated the direction judicial decisions on informed consent are likely to take. The Supreme Court ruled in favour of patient autonomy, rather than paternalism. It endorsed the right of patients to decide the course of their treatment rather than leave it to physicians' ethical obligation to preserve life.

However, on the specific facts of the case, the Supreme Court did not take into account how the refusal of blood treatment by the patient was primarily caused by the conditioning effect of her religious membership.⁴³⁵ Perhaps if the patient had received a different kind of socialization or belonged to a different religious group, her decision would have been different. On this view, it may be argued that her decision is a product of her socialization as was arguably the case in *JM v The Board of Management of St Vincent's Hospital*. Knowing this, would the physician have been justified in transfusing blood despite its rejection? This is even more complex where the patient has reflected

⁴³¹ Donnelly, *supra* note 1 at 49.

⁴³² See Alfred I Tauber, "Sick Autonomy" (2003) 46:4 Perspectives in Biology and Medicine 484 at 486.

⁴³³ *Ibid.*

⁴³⁴ *MDPDT v Okonkwo*, *supra* note 335.

⁴³⁵ Compare *JM v The Board of Management of St Vincent's Hospital*, *supra* note 213 [2003] 1 IR 321.

upon and adopted the religious norms as her own, and acted based on a personal conviction.⁴³⁶ Perhaps, in this case, she is fully autonomous. Yet, it is still vexing to decide, as Diana Meyers suggests,⁴³⁷ that where the religious norms are uncritically adopted, she is not autonomous. Provided the patient understood and appreciated the consequences of her decision, and there was no evidence that she was otherwise unduly influenced to the extent that she could no longer think and decide for herself, her decision was validly respected by the physician and the Supreme Court's preference of autonomy over paternalism is sound.

However, the concept of autonomy cannot fully account for the ethical responsibilities of physicians. This is because the sense of responsibility exhibited by physicians, arguably, arises from their ethical obligation to preserve life and promote health, rather than from a set of rules designed to protect patient autonomy. Although physicians' ethical obligation includes respect for patients, yet, it is in beneficence that a more resonant expression of medicine's fundamental ethos is found.⁴³⁸ Patient autonomy cannot meaningfully exist in the absence of professional input to guide the exercise of such autonomy. On the other hand, professional decision without patient autonomy may eventuate in medical tyranny. Accordingly, both autonomy and paternalism ought necessarily to interplay with each other. The interplay contemplated is not dialectic where these principles are in conflict. Rather, it is one which creates a homeostatic balance where each principle balances the other in the pursuit of a common goal.⁴³⁹

The *Code of Medical Ethics*, in requiring physicians to provide professional advice on treatment options, seems to envisage such interplay between patient sovereignty and medical expertise. Accordingly, it is arguable that the decision making process requires

⁴³⁶ It does not seem that the patient in *JM v The Board of Management of St Vincent's Hospital* was definitely convinced about her belief and choice. Indeed, the patient had, at a point, accepted the transfusion, but changed her mind afterwards.

⁴³⁷ See Meyers, *supra* note 90.

⁴³⁸ Tauber, *supra* note 432 at 486 (citations omitted).

⁴³⁹ Loewy, *supra* note 6 at 63.

mutual participation of both the physician and the patient, with the physician ensuring that the choice of the patient is enlightened through proper disclosure of information, and professional advice on the options available to him or her.⁴⁴⁰ However, the patient is free to accept or reject the physician's recommendation.

Thus, while the process leading to the preferred option is collaborative, the ultimate decision should reflect patient autonomy. In other words, the process encompasses collaboration, autonomy, and accountability. Accountability determines who bears responsibility for the treatment outcome. Although the *Code* places the responsibility on the physician, this would be the case where the physician relies on his or her absolute discretion to decide the treatment to give. In the mutual decision process suggested, responsibility for the decision or outcome of treatment should be joint. Arguably, having a patient take responsibility for his or her decision encourages his or her participation in the decision-making process. At the same time, it does not excuse the physician from his or her ethical and professional duty of care.

For a patient to exercise the right of autonomy, such patient must be competent. In this, the *Code* is defective: it measures competence according to status. A consequence of this defect is that it unnecessarily widens the range of persons who may be treated paternalistically. This defect is discussed below.

4.3.2 *Prescription of Status Incapacity*

It was shown in Chapter Three that a threshold matter for informed consent is the determination of competency or capacity. This determines whether or not the decision of a patient will be sought at all, or where given, will be respected. In other words, competence determines which of the identified values underlying informed consent will prevail, that is, respect for autonomy or beneficence. As such, competence performs a

⁴⁴⁰ The *Code*, s 19.

gatekeeping function.⁴⁴¹ A finding of competence means that the patient is allowed to decide his or her treatment. On the other hand, a finding of incompetence may lead to a patient having treatment imposed on him or her based on the decision of a next-of-kin, who, ostensibly is acting in his or her best interest.

According to the *Code*, a competent patient is one who is not below the age of eighteen or who is not mentally impaired or unconscious.⁴⁴² This implies a status approach to competency: the status of being a child or a minor and the status of being diagnosed as mentally impaired. Each of these is discussed in turn.

4.3.2.1 The Minor in Nigerian Health Care

The *Code* provides that where a patient is below eighteen, he or she is not capable of giving consent; the consent must proceed from a next of kin. In this sense, incapacity is conflated with being a minor. There is no requirement to assess the minor's capacity to understand and appreciate the nature of decision to be made. The *Code* adopted the age of majority in Nigeria as the age of competence. The conflation of the age of majority with the age of competence may stem from the law of contract under which an infant, that is, a person under the age of majority, is incapable of entering into valid contracts or incurring legal obligations therefrom. However, even this contractual principle admits of several exceptions where an infant can be bound to his or her contract, such as in some cases of contracts for necessities. Perhaps, the uncertainty about whether certain treatments qualify as necessities which may bind a child, contributes to the desire to obtain the consent of an adult who might be bound.⁴⁴³

As argued in Chapter Three, the test of capacity for a minor is highly functional and subjective across jurisdictions. This means that the test varies from one child to another and from one decision to another. For example, a 12-year old may be possessed of

⁴⁴¹ Devereux & Parker, *supra* note 188.

⁴⁴² The *Code*, s 19.

⁴⁴³ Rozovsky, *supra* note 188 at 61.

sufficient maturity to consent to receive contraceptive advice. Another 12-year old may not have the same maturity. Similarly, a 14-year old may be able to consent to treatment with relatively minor consequences, but may be found incompetent to consent to more complex ones such as a sex reassignment.⁴⁴⁴ A functional assessment does not rely on a blanket presumption of incapacity. Rather, it assesses whether the particular child is capable of consenting to the particular procedure, having regard to the age, maturity and understanding of the child and the nature and complexity of the procedure.

Conflating age with incapacity implies that notwithstanding how enlightened about his or her illness a patient is, as long as he or she is below the legal threshold, he or she is automatically barred from making his or her own decision and has to be treated paternalistically, in his or her best interest, as determined by someone else. The significance of this for informed consent is large. Available statistics indicate that the Nigerian population is very young; over 40% of Nigerians are under the age of 14,⁴⁴⁵ and about 51% are under the age of 18 years.⁴⁴⁶ This implies that over half of the Nigerian population is, automatically, medically incompetent and may be treated paternalistically. But this is only one arm of the excuse for paternalism. Another automatic recourse to paternalism is in the case of the mentally impaired.

⁴⁴⁴ See for example *Re A (a child)*, [1993] FLC 92-402 (Aust Fam Ct).

⁴⁴⁵ Index Mundi, "Nigeria Demographics Profile 2012" (www.indexmundi.com/nigeria/demographics_profile.html); Central Intelligence Agency, "The World Fact Book" online: (<https://www.cia.gov/library/publications/the-world-fact-book/geos/ni.html>).

⁴⁴⁶ See Stephen Davis, "No Arab Spring in Nigeria" Online: <http://www.nigeriavillagesquare.com/guest-articles/no-arab-spring-in-nigeria.html> 2011 ("in 2008 Nigeria's population was 150 million with 51 percent under 18 years of age").

4.3.2.2 The Mentally Impaired

Numerous studies on mental impairment show that it is highly prevalent in Nigeria.⁴⁴⁷ Severely mentally impaired persons do not pose much assessment difficulties. However, the *Code of Medical Ethics* does not make a distinction between severe mental impairment which renders a patient incapable of being held responsible for any decision made because he or she lacks the cognitive capacity, and mild mental impairment in which the person is able to function normally to an extent and to make some decisions affecting him or her. The former consists of cases where the impairment is so severe as to make a patient unable to understand and appreciate the nature and consequences of the decision to be made. The latter would include where, though the patient may have trouble with memory, language, thinking or judgment, it does not interfere with his or her daily life or activities, so that he or she is still capable of cognitive functioning, albeit at a relatively reduced level. It has been found that although mental disorders are common in Nigeria, they are usually of a mild nature.⁴⁴⁸ A large proportion of those with such disorders manage to function without considerable limitations.⁴⁴⁹

Further, studies have shown that physicians are generally only able to detect severe mental disorders and not their mild manifestations.⁴⁵⁰ Consequently, if every mentally impaired patient, whatever the degree of impairment, is incompetent, arguably even

⁴⁴⁷See for example Mohammed Kabir *et al*, "Perception and Beliefs about Mental Illness Among Adults in Karfi Village, Northern Nigeria" (2004) 4:3 BMC International Health and Human Rights (www.biomedcentral.com); Abdel-Hamid Afana *et al*, "The Ability of General Practitioners to Detect Mental Disorders among Primary Care Patients in a Stressful Environment: Gaza Strip" (2002) 24:4 Journal of Public Health Medicine 326.

⁴⁴⁸ See Oye Gureje, Victor O Lasebikan, Lola Kola & Victor A Makanjuola, "Lifetime and 12-Month Prevalence of Mental Disorders in the Nigerian Survey of Mental Health and Well-Being" (2006) 188 British Journal of Psychiatry 465.

⁴⁴⁹ See for example Gureje, *et al*, *ibid*; WHO World Mental Health Survey Consortium, "Prevalence, Severity and Unmet Need for Treatment of Mental Disorders" (2004) 291 JAMA 2581; RV Bijl *et al*, "The Prevalence of Treated and Untreated Mental Disorders in Five Countries" (2003) 22 Health Affairs 122.

⁴⁵⁰ Abdel-Hamid Afana *et al*, "The Ability of General Practitioners to Detect Mental Disorders among Primary Care Patients in a Stressful Environment: Gaza strip" (2002) 24:4 Journal of Public Health Medicine, 326.

where his or her impairment is not detected, the patient's decision is invalid. This is because, as mentioned earlier, a valid consent must flow from a person who is competent. Because competence under the *Code* is based on belonging to the class of minors or the class of mentally impaired, it follows that once a patient is a member of either class, irrespective of whether the physician is aware of the patient's status, or is mistaken about it, the patient cannot give a valid consent.

The impact on informed consent of competence based on belonging to the class of mentally impaired is, as with the case of a minor, a testimony to the prevalence of paternalism in Nigerian health care. Available statistics show that at any point in time, about 10% of the adult Nigerian population suffers from a mental illness and around 20% of all patients seen by primary health care providers, have one or more mental health disorders.⁴⁵¹ If, based on the *Code*, this group of persons is incompetent, whether severely mentally impaired or mildly impaired it further reduces the number of persons whose autonomy can be respected. For the seriously impaired, it seems that their autonomy does not suffer as it does not exist given their clear lack of capacity for self-determination. For the mildly impaired, overriding their preference or imposing treatment on them without a functional assessment of their ability to understand and make decisions for themselves would violate their right of self-determination.

A functional provision of competency in the *Code* would read:

“A person shall be deemed incompetent if by reason of age or mental impairment he or she is unable to understand and appreciate the information that is necessary to make an informed decision regarding his or her treatment.”

The above construction properly captures the functionality of competence. It avoids the rigid status approach, and respects the patient's self-determination. The proposed

⁴⁵¹ Mohammed Kabir *et al*, “Perception and Beliefs about Mental Illness among Adults in Karfi Village, Northern Nigeria” (2004) 4:3 BMC International Health and Human Rights (www.biomedcentral.com).

construction does not negate the presumption of competence in adults.⁴⁵² Rather, it obviates the necessity of a competence assessment where the individual is clearly of age and there is no indication of incompetence. For persons below majority or cognitively impaired, it provides an opportunity for them to demonstrate that they are not unduly affected by their age or mental condition.

Where a patient is incompetent, decision-making power shifts to his or her next-of-kin, where one is available. In this respect, the *Code* does not specify how the next of kin may be identified, in terms of priority, and what should guide the next-of-kin in making a decision for the patient. This shortcoming is discussed below.

4.3.3 *Lack of Definition of Next of Kin*

As already stated, a determination of incapacity according to the *Code* means that authorization for treatment will be given by a next-of-kin. The *Code* is silent on who qualifies as next-of-kin and whether the appellation can be interpreted to include persons in close relationship with the patient, but who are not related to him or her. This is particularly important given that the nature of activity contemplated is one touching on the dignitary interest of the patient. Since Nigeria, essentially, operates a private health care system, it also involves administration of or forbearance from treatment which the person so authorizing bears responsibility for the costs of treatment, the welfare of the patient while in hospital, and liability in the event that a suit ensues. Should a next of kin be limited to persons connected to the patient by blood even in cases where the emotive element of kinship is undeveloped?

Canadian legislation, Ontario, for example, is very instructive on decision making where a patient is found incapable of deciding his or her treatment. The Ontario *Health Care*

⁴⁵² See *Re C (Refusal of Medical Treatment)*, [1994] 1 FLR 31 at 35, where Thorpe J said: “Prima facie, every adult has the right and capacity to decide whether or not he will accept medical treatment, even if a refusal may risk permanent injury to his health or even lead to premature death.”

Consent Act provides, in ranking order, persons who can authorize treatment in the event that the patient is found incompetent. These persons include:⁴⁵³

- (i) The incapable person's guardian, if the guardian has authority to give or refuse consent to the treatment.
- (ii) The incapable person's attorney for personal care, if the power of attorney confers authority to give or refuse consent to the treatment.
- (iii) The incapable person's representative appointed pursuant to the Act, if the representative has authority to give or refuse consent to the treatment.
- (iv) The incapable person's spouse or partner.
- (v) A child or parent of the incapable person, or a children's aid society or other person who is lawfully entitled to give or refuse consent to the treatment in the place of the parent. This paragraph does not include a parent who has only a right of access. If a children's aid society or other person is lawfully entitled to give or refuse consent to the treatment in the place of the parent, this paragraph does not include the parent.
- (vi) A parent of the incapable person who has only a right of access.
- (vii) A brother or sister of the incapable person.
- (viii) Any other relative of the incapable person.

Any of the foregoing persons may authorize treatment only if that person is:⁴⁵⁴

- (a) competent with respect to the treatment;
- (b) is at least 16 years old, unless he or she is the incapable person's parent;
- (c) is not prohibited by court order or separation agreement from having access to the incapable person or giving or refusing consent on his or her behalf;
- (d) is available; and
- (e) is willing to assume the responsibility of giving or refusing consent.

⁴⁵³ *Health Care Consent Act, 1996 s 20(1).*

⁴⁵⁴ *Health Care Consent Act, 1996 s 20(2).*

Where none of the above indicated persons meets the requirement,⁴⁵⁵ or where there is a conflict between any of them,⁴⁵⁶ the Public Guardian and Trustee shall make the decision. In making the decision whether to authorize treatment or not, the person so authorizing shall first, act in accordance with any advance directive or expressed wishes of the incompetent person made while he or she had capacity and after attaining the age of 16 years. In the absence of any such expressed wishes or where the same cannot possibly be carried out, the person authorizing or refusing treatment shall only act in the best interest of the incompetent person.⁴⁵⁷

The Ontario *Health Care Consent Act* further provides for how the incapable person's best interests may be determined.⁴⁵⁸ This includes consideration of the values and beliefs that the person knows the incapable person held when capable, and believes he or she would still act on if capable, and any expressed wish of the incapable person. Specifically, the person authorizing treatment is to consider:

- (a) Whether the treatment is likely to (i) improve the incapable person's condition or well-being; (ii) prevent the incapable person's condition or well-being from deteriorating, or (iii) reduce the extent to which, or the rate at which, the incapable person's condition or well-being is likely to deteriorate.
- (b) Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without the treatment.
- (c) Whether the benefit the incapable person is expected to obtain from the treatment outweighs the risk of harm to him or her.
- (d) Whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed.

⁴⁵⁵ *Healthcare Consent Act*, 1996 s 20(5).

⁴⁵⁶ *Health Care Consent Act*, 1996 s 20(6).

⁴⁵⁷ *Health Care Consent Act*, 1996 s 21(1).

⁴⁵⁸ *Health Care Consent Act*, 1996 s 21(2).

Similarly, the *National Health Act, 2003* of South Africa⁴⁵⁹ provides, in order of priority, for persons who may authorize treatment where a patient is incompetent. These include a person mandated by the patient in writing, a person authorized by law or court order, a spouse or partner, a parent, grandparent, adult child, brother or sister.⁴⁶⁰ There is no similar provision in Nigerian law stipulating: how authorizations for treatment may be made in the event that a patient is incompetent; the rankings in order of priority of the patient's next-of-kin; and how, if at all, the patient's best interests may be determined. It is not even clear whether the next-of-kin, in making the decision, should be concerned about the patient's best interest. The *Code* only requires the next-of-kin to "stand in."⁴⁶¹ In other words, the next-of-kin takes the place of the patient and is not expressly constrained or limited by considerations such as the best interest of the patient.

It is argued that for a next-of-kin to be able to authorize treatment which is in the interest of the patient, he or she must know what those interests are. This implies that he or she must have had personal contact with the patient within a time frame sufficient to enable him or her to decipher what is likely to be in the patient's best interest.

It is suggested that a construction of next-of-kin should be broad enough to encompass persons who have had close contact with the patient and have shared intimate relationships with him or her. The increasing rate of urbanization in Nigeria and the struggle to earn a living has placed significant strain on close familial ties.⁴⁶² It has led to individuals cultivating relationships which are, in some cases, stronger than familial ties, perhaps as a result of shared struggles and experiences. These persons would be more likely to better decide treatment that will cohere with the patient's interests, rather than a relative who has neither the affection nor the knowledge of the patient's interest.

⁴⁵⁹ *National Health Act, 2003* (Act No 61 of 2003) s 7.

⁴⁶⁰ *National Health Act, 2003* (Act No 61 of 2003) s 7(1)(a) and (b).

⁴⁶¹ The *Code* s 19.

⁴⁶² See Ezeome & Marshal, *supra* note 10.

A competent patient, or the decision maker, requires certain information in order to be able to reach a knowledgeable decision. While other jurisdictions have a standard for measuring the materiality of information to be disclosed, the *Code of Medical Ethics* is silent. This leaves the materiality and adequacy of information uncertain. This uncertainty is reflected in actual practice. The shortcoming of the Code in respect to the nature, scope and materiality of disclosure is discussed over the next two sub sections below under absence of scope of disclosure and lack of contextually based treatment options.

4.3.4 *Absence of Scope of Disclosure*

The importance of informed consent, as highlighted in Chapter Two, is to give expression to the right of self-determination. This right is almost meaningless if the patient does not receive the information necessary to be effectively self-determining. Consequently, physicians are given the duty to provide patients with information necessary to enable them to make informed decisions. As discussed in Chapter Three, the materiality of the information provided by physicians is measured by two standards: the professional standard and the patient standard.⁴⁶³ The *Code of Medical Ethics* does not have a clearly identifiable standard for measuring the adequacy and materiality of information to be disclosed by physicians.

The *Code* provides that the physician is to disclose “the attendant benefits and risks”⁴⁶⁴ of the treatment to the patient. But it does not qualify the duty to disclose or indicate by what standard a physician’s compliance with this requirement may be measured. Two possible interpretations arising from the provision are: (i) the *Code* contemplates a full disclosure of every risk attendant upon treatment, however remote or immaterial; and (ii) by default, the *Code* allows the materiality of the information disclosed to be determined by physicians.

⁴⁶³ See Chapter Three for a discussion of the weaknesses of each standard.

⁴⁶⁴ The *Code*, s 19.

Requiring physicians to provide patients with information of every risk that may occur following the treatment is, arguably, impracticable. This is not only because physicians may not have this information, it also confuses the purpose of informed consent. To demand a full disclosure of risks is to prescribe, essentially, a crash course on medical risks. In effect, it encourages a monotonous recitation of every possible and probable risk, including the routine risk of infection from surgery.⁴⁶⁵ It does not, however, advance patient autonomy. Rather, inundating patients with unnecessary information may hinder the actual exercise of their autonomy. Thus, this interpretation ought to be rejected. As noted by Justice Linden, “[Physicians’ duty to disclose] does not mean that [physicians] must now give complicated seminars on medicine to all of their patients. It does mean, though, that more time may have to be spent explaining things to their patients than in the past.”⁴⁶⁶

Rejecting the interpretation that the *Code* intends full disclosure of risks to patients leaves the default position by which the materiality of information to be provided is determined by the physician. This, in essence, contemplates a professional standard by which the materiality of information to be disclosed is based on the discretion of the physician. The shortcomings of this standard are discussed in Chapter Three.

As seen from the studies on the opinions and practices of informed consent in Nigeria, physicians perform poorly when it comes to providing necessary information to patients. The studies also suggest that the general practice of informed consent is, at best, arbitrary. It is argued that an important factor in the arbitrariness of disclosure is the lack of definition of the standard of disclosure which, consequently, leaves the scope and content of disclosure to physicians. The situation is different in other

⁴⁶⁵ See *Reibl v Hughes*, *supra* note 27. However, it is arguable whether possibility of infection from surgery is general knowledge.

⁴⁶⁶ *White v Turner* (1981), 15 CCLT 81 at 104 (Ont HC), *aff’d* (1982), 12 DLR (4th) 319 (CA).

countries like Canada, where materiality of the information determines its disclosure and it is the patient, though a reasonable patient, who determines what is material.⁴⁶⁷

Based on the foregoing, it is evident that the *Code of Medical Ethics* fails to impose a clear duty on physicians to inform the consent of patients. Rather, allowing physicians to rely on their discretion in disclosing risks encourages paternalism on their part, in the sense that the physician may withhold information from the patient which they do not think the patient should have. It also maintains the traditional perception of physicians as authoritarian figures who control the treatment process.

Since the goal of informed consent is for patients to participate in decision making about their healthcare, it is suggested that the physician's duty to disclose be measured by what it takes for the patient's decision to be informed. In other words, it is suggested that the standard of disclosure in Nigerian healthcare be an informed standard.⁴⁶⁸

4.3.5 *Contextually Based Treatment Options*

Following from the above, the scope and extent of information which will be deemed adequate for informed consent should be that which would serve to make the patient's consent informed. Though this sounds cyclical, it underscores the fact that the purpose of requiring disclosure of information will not be met if the patient does not receive the information that is relevant to him or her, or if he or she does not understand the information that is given to him or her. As already argued, the scope of disclosure should not be what a reasonable physician would ordinarily disclose, or what a reasonable patient would want to be told. Rather, informed consent implies that the sufficiency of information be what is required to ensure that patients (or authorized surrogates) comprehend the implication of any decision made.

The information to be disclosed is not confined to risks but must extend to other information, such as alternatives to treatment and the risks associated with those

⁴⁶⁷ See *Hopp v Lepp*, *supra* note 42; *Reibl v Hughes*, *supra* note 27.

⁴⁶⁸ See Chapter Three.

alternatives.⁴⁶⁹ Accordingly, the *Code of Medical Ethics* requires treatment options to be presented to the patient.⁴⁷⁰ Also, section 23(1)(b) of Nigeria's *National Health Bill* provides:

“(1) Every health care provider shall give a user relevant information pertaining to his state of health and necessary treatment relating thereto including:
(b) the range of diagnostic procedures and treatment options generally available to the user;”

The risks of treatment⁴⁷¹ do not take on different meanings for Nigerian patients compared to patients in Canada and elsewhere. However, the issue of treatment options is one which has a particular significance to a Nigerian patient. This is because Nigerians have several indigenous means of treating various illnesses which are not acknowledged in western bioethics. These indigenous means have been described, in comparison to western medicine, using terms such as supernatural against natural, unscientific against scientific, primitive against modern, and uncivilized against civilized.⁴⁷² According to Iyioha, these descriptions are not heuristic devices to facilitate understanding of the different medical cultures of non-western peoples. Rather, she says they are part of “a linear agenda”, entrenched in “imperialism” and “geared towards ‘establishing’ the supremacy of western ideologies over the worldviews of the [non-western peoples].”⁴⁷³

By definition, indigenous medicine

⁴⁶⁹ Picard & Robertson, *supra* note 102 at 130.

⁴⁷⁰ The *Code*, s 19.

⁴⁷¹ For a detailed discussion about risks, see Picard & Robertson, *supra* note 102 at 120-29. See also *Hopp v Lepp*, *supra* note 42; *Reibl v Hughes*, *supra* note 27.

⁴⁷² Irehobhude Otibhor Iyioha, *Health Governance, Medical Pluralism and the Politics of Integration: A Legal Theory for Increasing Access to Healthcare* (Doctoral Thesis, University of British Columbia (Vancouver), 2010) [unpublished] at 54 [*Health Governance, Medical Pluralism and the Politics of Integration*].

⁴⁷³ *Ibid.*

comprises the totality of therapeutic knowledge, methods and systems, including the natural, psychosomatic, psychosocial and mystical, employed in maintaining health or preventing, diagnosing and treating illness, which are based on mechanisms and theories that may or may not be explicable through western biomedical philosophy; the methods and systems typically employ plant, animal and other mineral resources in combination or independently in the therapeutic process.⁴⁷⁴

The World Health Organization defines indigenous medical practice as “diverse health practices, approaches, knowledge and beliefs, incorporating plant, animal, and/or mineral based medicines, spiritual therapies, manual techniques and exercises applied singularly or in combination to maintain well-being, as well as to treat, diagnose or prevent illness.”⁴⁷⁵

Both definitions capture the essential features or elements of indigenous medicine. However, the former definition particularly highlights the features which distinguish indigenous medicine from western biomedicine. The features or elements include the natural, supernatural, psychosomatic and psychosocial, and social elements.⁴⁷⁶ These elements identify the origin of diseases as they are perceived within the cultural setting. Relying on Baronov’s analysis, the natural elements relate to observable and measurable forces within the physical world such as pollution, infection and contagion, as the causes of illnesses.⁴⁷⁷ It also relates to the use of natural materials like herbs, roots and plants for treatment. The supernatural elements relate to factors which transcend the natural as the causes of illnesses.⁴⁷⁸ Baronov argues that transcendental forces like religious deities or ancestral spirits are believed to possess powers which

⁴⁷⁴ *Ibid* at 56.

⁴⁷⁵ World Health Organization Traditional Medicine Strategy 2002-2005, online: World Health Organization http://whqlibdoc.who.int/hq/2002/WHO_EDM_TRM_2002.1.pdf.

⁴⁷⁶ See Chidi Oguamanam, *International Law and Indigenous Knowledge: Intellectual Property, Plant Biodiversity and Traditional Medicine* (Toronto: University of Toronto Press, 2006) at 111-118; David Baronov, *The African Transformation of western Medicine and the Dynamics of Global Cultural Exchange* (Philadelphia: Temple University Press, 2008) at 128-152.

⁴⁷⁷ *Ibid* at 128-129.

⁴⁷⁸ *Ibid* at 128.

enable them to interfere with the physical world and cause illnesses.⁴⁷⁹ Such illnesses cannot be analyzed or treated through physical means, as in the case of natural elements. Rather, they require knowledge of the interaction between the supernatural and the natural.⁴⁸⁰

The psychosomatic and psychosocial elements operate to link certain illnesses to emotional or social factors, and highlight the interconnectedness of the body and the mind.⁴⁸¹ Each of the elements- natural, supernatural, psychosomatic and psychosocial- interacts on an ongoing basis to underscore the fourth element, and the core organizing principle of indigenous medicine, which is holism.⁴⁸² This holism complicates the attempt to separate the natural element from the other elements, as done in biomedicine.⁴⁸³ This holism is not adequately reflected in the *Code of Medical Ethics* and in the *National Health Bill*.

To present a patient with only conventional treatment options which may not have any significant meaning to him or her, arguably, may not inform his or her decision whether to accept treatment. When patients are informed about treatment options, apart from conventional ones, they should, where there is evidence that they are effective, also be informed about other indigenous alternatives, their benefits and risks.⁴⁸⁴ This is more so when the efficacy of such alternatives is so well established that a physician would be negligent in failing to disclose them.

⁴⁷⁹ *Ibid.*

⁴⁸⁰ *Ibid* at 129.

⁴⁸¹ Iyioha, *Health Governance, Medical Pluralism and the Politics of Integration supra* note 472 at 57.

⁴⁸² Baronov, *supra* note 476 at 130.

⁴⁸³ Iyioha, *Health Governance, Medical Pluralism and the Politics of Integration, supra* note 472 at 57-58.

⁴⁸⁴ Joan Gilmour *et al*, "Informed Consent: Advising Patients and Parents About Complementary and Alternative Medicine Therapies" (2011) 128: Suppl 4 Pediatrics S187 at S188

It is understandable that physicians who are not convinced about the benefits of indigenous medicine may be reluctant to provide them to patients as options. This is especially where research data about their benefits are unavailable or inconclusive.⁴⁸⁵ Where reliable evidence shows that indigenous alternatives have more benefits compared to the conventional ones, such alternatives should be disclosed. An example is where there is scientific evidence that an indigenous alternative has fewer or milder side effects than conventional treatment. Where physicians are unable to offer such indigenous treatment, they may offer to arrange a referral.⁴⁸⁶

The question remains whether the physician is obligated to disclose indigenous alternatives. According to Joan Gilmour *et al*,

[T]he obligation to discuss alternative treatment choices in addition to those proposed by the treating physician is not unlimited. Although the boundaries of the obligation have not been well developed in case law, the alternative should offer at least the prospect of some therapeutic benefit; that is, it must be reasonable to consider it to be an alternative.⁴⁸⁷

The foregoing view may be read into both the *Code*⁴⁸⁸ and the *National Health Bill*.⁴⁸⁹ Though silent about it, the requirement that treatment options or alternatives be disclosed to the patient, may be taken to mean a duty to disclose such alternatives that offer some prospect of therapeutic benefits which are generally recognized, and which a physician would be negligent in not disclosing. Given that even within conventional medicine, physicians may disagree about what treatments are appropriate, a physician who does not support an indigenous alternative even where it is scientifically proven to be effective should, nonetheless, if it is part of his or her duty and standard of care, disclose it to the patient and the reason he or she thinks the alternative is

⁴⁸⁵ *Ibid.*

⁴⁸⁶ *Ibid* at S189.

⁴⁸⁷ *Ibid.*

⁴⁸⁸ The *Code*, s 19.

⁴⁸⁹ *National Health Bill* (SB. 58) s 23(1)(b).

inappropriate.⁴⁹⁰ This would enable a patient to make a reasoned decision assisted by the physician's assessment and recommendation.

However, for a physician to provide these indigenous alternatives, it has to be commensurate with his or her duty of care.⁴⁹¹ Arguably, where scientifically tested indigenous alternatives offer a better outcome, or less severe side effects, or similar outcome at a reduced cost, physicians owe patients the duty to present such alternatives. Whether this duty extends to unproven indigenous treatments is uncertain. Anecdotal evidence in Nigeria suggests that some physicians have been known to suggest that a patient's illness may have supernatural causes that require more than orthodox medicine can provide.⁴⁹² However, in countries like Canada and the US, providing indigenous alternatives or "fringe" alternatives is, currently, not the standard practice and may not meet a physician's duty of care.⁴⁹³

In *Santos v Traff*,⁴⁹⁴ it was held that there is no duty upon the physician to advise of "fringe" or dangerous alternatives.⁴⁹⁵ In particular the court stated that "common sense suggests that failure to [advise] of alternatives might be applied most successfully against a doctor who uses the fringe alternative or one not generally accepted by the medical profession as being within the standard of care, and fails to inform of the medically accepted mainstream alternative."⁴⁹⁶

The above dictum implies that disclosing only "fringe" options does not discharge his or her duty to disclose alternatives because the physician is not obligated to disclose those "fringe" alternatives. It implies that a physician has not met the standard of care in

⁴⁹⁰ Picard & Robertson, *supra* note 102 at 151.

⁴⁹¹ *Moore v Baker*, 989 F 2d 1129 (1993)

⁴⁹² See Jane John-Nwankwo, "The Effect of Culture on Health Care" July 26, 2009 Online: www.theeffectofcultureonhealthcare.blogspot.ca

⁴⁹³ See generally Gilmour *et al*, *supra* note 484.

⁴⁹⁴ *Santos v Traff* (1999), ABQB 630.

⁴⁹⁵ *Ibid* at para 49.

⁴⁹⁶ *Ibid*. See also *Seney v Cooks* (1998), ABCA 316.

disclosing *only* the fringe alternatives. It is not clear whether the standard of care would still not be met where the physician discloses the “fringe” alternatives *and* the mainstream options. What seems clear is that the physician is not under obligation to provide such alternative unless it is part of the standard of care.

Similarly, in *Moore v Baker*,⁴⁹⁷ a patient sued a physician for failing to disclose an alternative therapy to her. In determining whether the physician incurred any liability under the Georgia statute which requires disclosure of alternative treatments, the court held that an alternative must be one that is accepted in the medical community.

A patient who has always relied on indigenous medicine may not be satisfied with information about only conventional alternatives. This is especially where the medical outcome of using either indigenous medicine or conventional medicine is similar, but indigenous medicine has fewer side effects or has a lower cost. Whether integrating conventional and indigenous medicine is possible, and the mechanics of such integration, requires further research. But the prospect is one that is desirable and would, arguably, provide a Nigerian patient with comprehensive care and a range of options. However, where a patient asks questions about indigenous alternatives the physician should answer the question to the best of his or her ability.⁴⁹⁸

Following disclosure of the necessary information, and understanding of same by a competent patient, the decision whether or not to submit to treatment, including the nature of treatment, must be made by the patient.⁴⁹⁹ As seen in Chapter Three, such decisions must be voluntary, without fraud, duress, misrepresentation, undue influence or oppression. Whether this is also the case in Nigeria is not clear, as the *Code of Medical Ethics* does not explicitly say so. This identified shortcoming is discussed next.

⁴⁹⁷ *Moore v Baker*, 989 F 2d 1129 (1993).

⁴⁹⁸ See *Reibl v Hughes*, *supra* note 27 at 4.

⁴⁹⁹ The *Code* s 19.

4.3.6 *Silence about Voluntariness*

Added to the foregoing shortcomings of the *Code of Medical Ethics*, is the uncertainty of whether the consent of the patient must be voluntary. There is no express provision in the *Code* for a voluntary decision. The *Code* only says that the patient is to choose the preferred option. The absence of a specific requirement of voluntariness is problematic. It implies that however the patient came to his or her decision, whether or not his or her will was overwhelmed or undermined by external factors, it is valid. This is different from the position in other jurisdictions, like Canada, USA, UK, and Australia where consent obtained by coercion or undue influence is invalid.⁵⁰⁰

It may not be straightforward to impute voluntariness to informed consent where the *Code* is silent on it. This is especially so, given the prevalent communal process of decision making in a typical Nigerian family. Perhaps the omission is deliberate to reflect such a process which, seen in the light of cases such as the English case of *Re T (Adult: Refusal of Medical Treatment)*,⁵⁰¹ may be held to be undue influence. In *Re T*, a 21 year old woman who was 34 weeks pregnant refused to consent to a blood transfusion following a private conversation she had with her mother who was a Jehovah's Witness. The patient's father successfully applied to the court for an order authorizing the blood transfusion. On appeal, the Court of Appeal held that the patient's refusal was due to undue influence from her mother, and was thus, vitiated.

It is uncertain whether, on a similar set of facts, the Nigerian Courts will decide in the same way. While it is desirable to explicitly require consent to be voluntary, it may be inaccurate to classify the absence of such explicit requirement as a shortcoming of the *Code*, when it may, in fact, be an acknowledgement of the existence of factors that influence patients' decisions. Some of such factors derive from the social context of the

⁵⁰⁰ *Norberg v Wynrib*, *supra* note 206 at 457.

⁵⁰¹ *Re T (Adult: Refusal of Medical Treatment)*, *supra* note 50.

individual from which it may be difficult to escape. This is discussed as challenges to informed consent in Nigeria which are explored in Chapter Five next.

4.4 Conclusion

The preceding analysis of the Nigerian law provisions on informed consent has shown that right to informed consent is, indeed, part of constitutionally protected rights and of the common law in the country. It has also shown that the *Code of Medical Ethics* covers the threshold matters of competence, surrogate decision making, disclosure and patient decision.

At first blush, these elements resemble those on the subject in any developed Western country. On closer scrutiny, it was found that the *Code* has several shortcomings, such as lack of clarity about who makes the decision; prescription of competence based on status; lack of definition of next of kin; lack of a standard for measuring the duty to disclose. It was also found that adherence to the western model of informed consent may not satisfy a Nigerian patient, especially in light of the meaning of “options to treatment” and “voluntariness.” It was suggested that the shortcomings can be cured. For instance, a functional assessment of competence was suggested in place of competence by status, and, for disclosure, it was suggested that both materiality and adequacy of information be measured by the patient’s needs, and options should ideally include indigenous treatment.

Chapter Five next explains the shortcomings identified in this chapter. Essentially, it will seek to place in context the inadequacies in the provisions and practice of informed consent. To do this, the chapter looks at the setting or context of Nigeria through a relational lens, in terms of demographical, sociological and cultural constraints that limit the prevalence of a western-style practice of informed consent and the autonomy of patients in Nigeria.

Chapter Five

Informed Consent Practice in Nigeria

5.0 Introduction

The preceding chapters have established the importance and necessity of informed consent in protecting patient autonomy. Chapter Four showed that the practice of informed consent in Nigerian health care has not been satisfactory. This was traced to shortcomings in the *Code of Medical Ethics* such as lack of proper delineation of decisional authority, measuring competence by age or mental status, lack of definition of next-of-kin, lack of guidance on the scope and materiality of disclosure, and no express requirement of voluntariness. Because these shortcomings derive from within the medical profession itself, in particular, the law regulating it, they are referred to as legal or internal impediments to informed consent.

As indicated in Chapter One, and as the preceding chapters show, the notion of individuals and autonomy which guide discussion in this thesis is a relational one. The primary usefulness of this notion is that it brings to fore, autonomy impeding or enhancing factors within Nigeria, how they impede or enhance autonomy and how those that impede autonomy may be overcome. Particularly, a relational view generates a rhetorical tool in promoting the right of women in Nigeria to control their medical and reproductive care in a country that ascribes enormous powers to physicians and to male partners. General discussion in bioethics often involves a dichotomy between autonomy of patients and the paternalism of physicians.⁵⁰² However, in a blatantly patriarchal society like Nigeria, the divide is not necessarily between patient autonomy and physician paternalism. Rather, it extends to the interests of a woman's husband, her

⁵⁰² See Susan Sherwin, "Relational Autonomy and Global Threats" in Jocelyn Downie and Jennifer J Llewellyn, eds, *Being Relational: Reflections on Relational Theory and Health Law* (Vancouver: UBC Press, 2012) 13 at 15.

religious group, and the State in her reproductive life. A relational view shows that patients in Nigeria, especially women, cannot simply assert autonomy. Rather, they need to learn how to make decisions in a way that reflects their own values and preferences. It identifies oppression, especially oppressive socialization as an impediment to Nigerian women's ability to develop the skill they need to make their own decisions.

Empowering women in Nigeria may enhance their autonomy. However, it is also a great threat to their social bonds and long established relationships. This does not imply that self-determination is inherently opposed to social relationships. Rather, where a person questions and rejects certain norms that bind him or her to other people, he or she may want to change the relationship in a manner that disrupts it.⁵⁰³ Such disruption may also come from other persons who are not comfortable with her increasing assertions of autonomy. Marilyn Friedman observes that some parents disown children who rebel too strongly against deeply held parental values, and that peer groups may ostracize their members for disregarding important norms of their subculture.⁵⁰⁴

The exercise of autonomy does not necessarily disrupt social relationships. To Friedman, questioning one's commitments or group norms may lead to appreciating them in a new light, and may enrich such relationships. On this view, autonomy may actually strengthen relational ties rather than disrupt them. However, although the exercise of autonomy may not necessarily disrupt relationships, it increases the chances of disruption. A society that values autonomy encourages critical scrutiny of, and reflection on every aspect of social ties including religion, sex, gender, family, government, to a larger extent than a society which does not place much emphasis on autonomy.⁵⁰⁵ An autonomy-embracing society may have a higher number of voluntary relationships that are formed in adulthood around shared values, and a higher incidence of disruption in

⁵⁰³ Friedman, *supra* note 19 at 42.

⁵⁰⁴ *Ibid.*

⁵⁰⁵ *Ibid* at 43.

relationships into which people are born, and in which they received their first socialization.⁵⁰⁶ Such relationships as family, church, local communities may be disrupted in favour of voluntarily chosen ones. This is a possible consequence of enhancing autonomous capacities of individuals, particularly those in an oppressed group, as is the situation of women in Nigeria.

Bearing the foregoing in mind, the rest of this chapter focuses on the relational factors, that is, factors other than the provisions of the *Code*, which may explain or justify the unsatisfactory state of the concept of informed consent in Nigeria. The factors are presented as challenges to the observance of informed consent in Nigeria that is derived from the country's socio-cultural background. Nine challenges are identified. These range from general challenges, to cultural challenges affecting, primarily, the exercise of autonomy, and to challenges emanating from the difference in background between Nigeria and other jurisdictions where informed consent is practiced. Although the discussion centers on Nigeria and the challenges are, to a great extent, derived from the socio-cultural background of Nigeria, some of the challenges are not peculiar to Nigeria. Examples of the challenges that are not specific to Nigeria include trust, illiteracy and the relationality of autonomy.

It is argued that, despite the reality of cultural relativism, autonomy appears to be a universal concept. However, insisting on autonomy in the relationship between physician and patient, a relationship which is based on trust, is not entirely coherent. Thus, the first of three general challenges to informed consent is trust. This challenge affects the value protected by informed consent and transcends the socio-economic and cultural realities that define the Nigerian context of the discussion.

⁵⁰⁶ *Ibid* at 44.

5.1 Factors Influencing the Practice of Informed Consent in Nigerian Health Care

5.1.1 *Trust as a Challenge to Informed Consent*

An important element in the relationship between a physician and a patient is trust, and in that context, trust is both intrinsic and instrumental.⁵⁰⁷ It is critical to a patient's willingness to seek care, reveal sensitive information, submit to treatment, and follow a physician's recommendations.⁵⁰⁸ Effective treatment of a patient depends on the ability of the physician to elicit trust from him or her.⁵⁰⁹ Whether the physician succeeds in doing this depends on the patient's perception of physicians in general, and on the archetypal features of being a physician.⁵¹⁰

While it is argued that abuse of trust led to agitations for autonomy in healthcare generally through informed consent,⁵¹¹ empirical evidence in the UK and the US, demonstrates that although trust in the medical profession may have diminished somewhat, patients' trust in their physicians remains remarkably high.⁵¹² As used here,

⁵⁰⁷ Mark A Hall, Fabian Camacho, Elizabeth Dugan & Rajesh Balkrishnan, "Trust in the Medical Profession: Conceptual and Management Issues" (2002) 37:5 Health Services Research 1419.

⁵⁰⁸ *Ibid.*

⁵⁰⁹ David A Axelrod & Susan Dorr Goold, "Maintaining Trust in the Surgeon-Patient Relationship: Challenges for the New Millenium" (2000) 135 Archives of Surgery 55.

⁵¹⁰ T Govier, "An Epistemology of Trust" (1993) 2 International Journal of Moral and Social Studies 155; Hall *et al*, *supra* note 507; Susan Dorr Goold, "Money and Trust: Relationships Between Patients, Physicians, and Health Plans" (1998) 23 Journal of Health Politics, Policy and Law 688.

⁵¹¹ See Donnelly, *supra* note 1 at 14; David Rothman, *Strangers at the Bed Side: A History of How Law and Bioethics Transformed Medical Decision Making* (New York: Basic Books, 1991) at 15-18.

⁵¹² See Mary Donnelly, *supra* note 1 at 37; M Davies, *Medical Self-Regulation: Crises and Change* (Aldershot: Ashgate, 2007) 93. See also Zosia Kmietovicz, "R.E.S.P.E.C.T – Why Doctors are Still Getting Enough of it" (2002) 324 British Medical Journal 11; Hall *et al*,

trust refers to the willingness of a party (trustor) to be vulnerable to the actions of another party (trustee) on the expectation that the trustee will perform a particular action important to the trustor, irrespective of the trustor's ability to monitor or control the trustee.⁵¹³ Stated concisely, trust is an "accepted vulnerability to another's possible but not expected ill will (or lack of good will)."⁵¹⁴

Trust in the physician encourages dependence and the expectation that the patient's best interest will be served.⁵¹⁵ A feature of illness is that it fosters dependence. On the other hand, "autonomy sets its sights on another agenda altogether, one marked by freedom and independence that was forged in the fires of advocacy and conflict, dynamics foreign to medicine."⁵¹⁶ Informed consent, which is meant to protect this freedom and independence and to redress the power imbalance in the physician patient relationship, ignores the severity of the inequality between patients and physicians. Because of this inequality, patients cannot avoid "delegating authority, entrusting themselves to others, and then fretfully hoping that their best interests will be protected."⁵¹⁷ Consequently, while it may be the case that informed consent protects a patient's right of autonomy, a full expression of this freedom is constrained by trust in the physician.

As indicated, the challenge posed to the underlying value of informed consent by trust is not localized to Nigeria. However, its effect seems to be more pronounced in Nigeria. Anecdotal evidence suggests that Nigerian patients place very high trust in, and

supra note 507; Robert J Blendon & John M Benson, "Americans' Views on Health Policy: A Fifty-Year Historical Perspective" (2001) 20:2 Health Affairs 38.

⁵¹³ See Roger C Mayer, James H Davis & FD Schoorman, "An Integrative Model of Organization Trust" (1995) 20 Academy of Management Review 709.

⁵¹⁴ Annette Baier, "Trust and Antitrust" (1986) 96 Ethics 231.

⁵¹⁵ See Tauber, *supra* note 432.

⁵¹⁶ *Ibid* at 491.

⁵¹⁷ *Ibid* at 492; see also Carl E Schneider, *The Practise of Autonomy: Patients, Doctors, and Medical Decisions* (New York: Oxford University Press, 1998).

reverence for, physicians almost to the point of worship.⁵¹⁸ This raises the dependency of patients on physicians and an unquestioning attitude towards decision making by physicians. In turn, it limits the purpose and effect of informed consent.

5.1.2 *Relationality of Autonomy*

A second general challenge to informed consent is the relational characteristic of autonomy. This suggests that there is no such thing as an inherently autonomous person who can be distinguished from a non-autonomous person. Rather, a relational view of individuals reveals certain factors which influence and constitute the individual, and which may impede autonomous decision-making.

As a concept, autonomy is formed around social relationships.⁵¹⁹ Consequently, activities such as reflecting, choosing and deciding that make up self-determination are social in nature. The materials that enable reflection and decision-making are, arguably, products of a past conditioning. Such conditioning may be a consequence of socialization, as in patriarchy or religion. Reflection and decision-making may also be affected by availability of materials such as where there is inadequate or manipulated disclosure of information on the part of physicians in Nigeria. The foregoing may subjugate or overwhelm the decision making capacity of a patient.

A person who chooses to subordinate himself or herself to the controlling influences of physicians or religious and other beliefs may nonetheless be autonomous.⁵²⁰ Yet, it is

⁵¹⁸ See for example, Lawal, *supra* note 10 at 3 (“[patients] give consent because they look up to their doctors as their authorities and hence their guardians”); Ezeome & Marshall, *supra* note 10 (stating that patients actually see the fact that the physician asked them to make a choice as a sign of incompetence).

⁵¹⁹ Jennifer Nedelsky, “Reconceiving Autonomy: Sources, Thoughts and Possibilities” (1989) 1 *Yale Journal of Law and Feminism* 7.

⁵²⁰ Anne Donchin, “Autonomy and Interdependence: Quandaries in Genetic Decision Making” in Catriona Mackenzie & Natalia Stoljar, eds, *Relational Autonomy: Feminist*

questionable whether a person can deliberately choose the nature of his or her socialization, or escape its effect. It is expected that where a person is consistently taught a certain way of life or thought process, over time, the person tends to act or think according to such teachings. This raises questions about how autonomous such actions or thoughts of the person are. This is particularly so where the effect of such conditioning is to foster oppression or subjugation of a particular group, such as women. It may be challenging to assist persons, as patients, who are subject to oppressive influences, to maintain relations that enhance their self-identity, where the internalization of the conditioning effect of their socialization is near total.

It is possible that a patient may not fully realize his or her beliefs or be conscious of his or her values. For this patient to be able to make an autonomous decision may require an extensive exploration of his or her history and motivations.⁵²¹ It is also possible that the patient's self-perception may be confused with other's perception of and expectation from him or her. In this case, the patient may make a decision that others expect him or her to make rather than a decision that he or she, given his or her values and preferences, want to make.

As an element of informed consent, voluntariness suggests that a person who is fully autonomous can be distinguished from a person who is not, so that the question is the basis upon which the distinction is to be made. It does not take into account the various relational factors, as indicated above, which affect the ability of a patient to act autonomously. Other such factors may be due to the failure of physicians to provide and ensure the patient understands the information that is necessary for an informed decision. The impediments to autonomy may also be structural or environmental and may not necessarily be traced to inadequate disclosure.

Perspectives on Autonomy, Agency, and the Social Self (Oxford: Oxford University Press, 2000) 236 at 237.

⁵²¹ *Ibid.*

Studies have shown that persons with limited education may have difficulty understanding information necessary for an informed decision.⁵²² This is more so where the information is explained in an unfamiliar language. Both the *Code* and the *National Health Bill* suggest that the consent process must be carried out in the language the patient understands. It is arguable that unless the physician understands and is able to communicate in the patient's indigenous language, communication is more likely to be in English, or an adulterated version of it known as pidgin English. But even this "lower" form of English may still be difficult to understand for some patients, especially those living in rural areas who for some reasons, are in a city. There are over 500 languages in Nigeria.⁵²³ Requiring a physician to communicate or get someone who understands a patient's language, especially where the language does not fall within the major Nigerian languages, namely, Igbo, Hausa and Yoruba, may be difficult.

Similarly, an individual who has been gender-socialized to accept decision making by persons regarded as having authority over her may find it difficult or impossible to understand and appreciate the nature and implication of making a particular decision where she is called upon to do so. Such socialization may foster self-doubt in the individual to the point where she doubts her decision-making capacity, either with respect to the particular situation, or generally. Consequently, such self-doubt may affect her ability to understand and appreciate the nature and consequences of her decision.

The challenge, therefore, is to assess how physicians should proceed in the face of these relational influences. Generally, where patients lack competence, or where the degree of autonomy that may be exercised is reduced, the response is to treat the patient

⁵²² Raymont *et al*, *supra* note 156.

⁵²³ Central Intelligence Agency, "World Fact Book" online: <https://www.cia.gov/library/publications/the-world-factbook/geos/ni.html>.

paternalistically to ensure the best possible treatment for the patient.⁵²⁴ But paternalism may distort what is actually a patient's real interest, and is especially problematic where lack of competence is caused by the influence of relational factors such as patriarchy and religion. According to McLeod and Sherwin,

[o]ppression [which is a feature of patriarchy] involves unjust distributions of power, and health-care settings are sites of very uneven power differentials. If health-care professionals, especially physicians, further consolidate their already disproportionate power in relation to patients, especially those from oppressed groups, they exacerbate a problematic power differential and further reduce the already limited autonomy of their patients.⁵²⁵

This is apart from the fact that, having a different background, relationships and orientation, physicians may be unable to know what is ultimately in the patient's best interest. The solution may lie in empowering patients by removing the source of the oppression, and thereby, helping to restore their autonomy. This may well be beyond the capacity of physicians, especially since it may involve a large scale social change. However, when attending to patients from a paternalistic setting, physicians may help by looking beyond the prevalent stereotypical expectation of passivity from female patients which impede their autonomous agency, and encouraging active participation of the patients in decisions about their health care.

The import of the foregoing is that autonomy is a way of relating and may be better understood where the ability of each patient to be autonomous is seen within a network of relationships and cultural influences.⁵²⁶

⁵²⁴ See for example *Re T (Adult: Refusal of Medical Treatment)*, *supra* note 50; *JM v The Board of Management of St Vincent's Hospital*, *supra* note 213.

⁵²⁵ McLeod & Sherwin, *supra* note 208 at 267.

⁵²⁶ Priscilla Alderson, "In the genes or in the stars? Children's competence to consent", in Michael Freeman, ed, *Children, Medicine and the Law*. (Aldershot: Ashgate, 2005) 549.

A third general challenge to informed consent is demographical. This challenge is particularly felt in the cost of obtaining consent, in terms of time and effort. Illiteracy and poverty, as challenges to informed consent in Nigeria, are discussed next.

5.1.3 *Illiteracy and Poverty as Challenges to Informed Consent in Nigeria*

Obtaining informed consent in Nigerian healthcare is affected by the degree of literacy and economic capacity of the patient. The effect of poverty and illiteracy on patient understanding, medical decision-making and compliance with treatment has been well researched and documented.⁵²⁷ Persons who lack social and economic power are likely to be occupied with meeting their material needs rather than be engaged in abstract ideals of rights and autonomy. Studies have shown that poor and illiterate persons tend to accept authority without question.⁵²⁸ A functional informed consent practice for Nigerian healthcare needs to take into account certain important aspects of the lives of the Nigerian people. These include political and socio-economic factors, illiteracy, language barriers, and cultural differences among patient populations.

Nigeria is a lower-middle-income country with severe economic disparities among its population.⁵²⁹ It is estimated that 70% of Nigerians live below the poverty line.⁵³⁰ It is also estimated that general literacy level in Nigeria is 68%.⁵³¹ This does not

⁵²⁷ See for example, Seth C Kalichman & Tamar Grebler, "Stress and Poverty Predictors of Treatment Adherence among People with Low-literacy Living with HIV/AIDS" (2010) 72(8) *Psychosom Med* 810; D Waldrop-Valverde *et al*, "The effects of Low Literacy and Cognitive Impairment on Medication Adherence in HIV-Positive Injecting Drug Users" (2008) 10 *AIDS Care* 1202.

⁵²⁸ Karen Politis Virk, "Clinical Trials in South Africa" (2009) online:

www.languageconnections.com/descargas/CLINICAL TRIALS IN SOUTH AFRICA.pdf.

⁵²⁹ The World Bank (2010) online: (www.data.worldbank.org/about/country-classifications).

⁵³⁰ Central Intelligence Agency, World Fact Book (www.cia.worldfactbook.com)

⁵³¹ Central Intelligence Agency, World Fact Book (www.cia.worldfactbook.com). For adult literacy, the estimate is 61%. See Unicef, Statistics (http://www.unicef.org/infobycountry/nigeria_statistics.html).

automatically mean that getting informed consent from uneducated or poor persons is impossible. Rather, it means that the process of doing so may be more tenuous and demanding on the physician, and may not make much difference. This is because first, poverty and illiteracy foster class difference and may lead to a feeling of reduced self-worth in patients of the lower class. In turn, it may compel them to accept and comply with a physician's treatment decision. Second, because poor and illiterate patients lack the means to institute and sustain a legal action for breach of their rights, there is no real reason to fear legal liability for failing to follow the consent process in Nigeria.⁵³²

Consequently, and as practical solution, physicians are more likely to seek consent when the patient is educated or enlightened,⁵³³ and are more likely to provide information to a lesser or greater extent as the patient's literacy level requires.⁵³⁴ It has also been found that economically dependent women with less education are more likely than others to seek permission from their husbands before seeking or accepting medical treatment or participating in clinical research.⁵³⁵ The significance of illiteracy and poverty on informed consent is noteworthy: if they can be reduced, a good deal of other challenges to informed consent may be overcome. Ezeome and Marshall capture the nexus between an improved literacy level and enhanced informed consent practice. They point out that:

The patient's level of education... seems to be an overriding factor in all the influences on informed consent in [Nigeria]. It not only neutralizes the various cultural and social factors, it bridges the gap between the doctor and the patient, encourages discussion on medical matters and also puts the physician on guard. If one considers that in 2007 60 million Nigerians have been estimated to be

⁵³² The absence of litigation is developed fully below as a challenge to informed consent.

⁵³³ See K A Agu, "Informed Consent Policy and Surgeons in Southeast Nigeria" (2003) 9 Niger J Surg 39.

⁵³⁴ See Osime *et al*, *supra* note 9.

⁵³⁵ Patricia A Marshall *et al*, "Voluntary Participation and Informed Consent to International Genetic Research" (2006) 96 Am J Public Health 1989.

illiterate, illiteracy may be a far more inhibiting factor on informed consent practices than any other factor.⁵³⁶

Thus, an effective and functional informed consent practice requires enlightened patients who know what they want, or while not certain about what they want, are able to process the information necessary for determining what they want. This requires concerted effort from the physician, through a hermeneutic approach, in order to enable the patient to overcome the barriers caused by illiteracy and poverty.

While not strictly peculiar to Nigeria, the next four challenges to informed consent are cultural. Two of the challenges are based on belief and affect cognitive engagement with the discourse leading to informed consent. They include beliefs about the causes of illness and religious belief in invincibility. The other two challenges refer to familial influence and stereotypical roles, and are derived from the conduct or expectations of persons other than the patient. All four challenges affect the exercise of autonomy or may make getting first person consent problematic. These challenges are discussed in turn below.

5.1.4 *Perception of Illness and Its Causes*

The belief that illness, especially insanity, is caused by metaphysical powers invoked by one's enemies, and has nothing to do with medicine is predominant in Nigeria.⁵³⁷ This belief affects the willingness of patients to access health care because it is assumed that western medicine has nothing to offer in dealing with it.⁵³⁸ This belief constitutes a

⁵³⁶ Ezeome & Marshall, *supra* note 10 citing J Onah, "UNESCO Laments the Level of Illiteracy in Nigeria" Business Day (Lagos Nigeria) 11 October 2007 Available online: <http://businessdayonline.com/print/508.html>.

⁵³⁷ See O F Aina, "Mental Illnesses and Cultural Issues in West African Films: Implications for Orthodox Psychiatric Practice" (2004) 30 Med Humanities 23.

⁵³⁸ Jane John-Nwankwo, "The Effect of Culture on Health Care" July 26, 2009 Online: (www.theeffectofcultureonhealthcare.blogspot.ca); Ilechukwu Sunday TC, "Cross

hindrance to a truly informed decision. For example, a man who recently got back from a visit to his country home only to develop a severe headache, or swollen ankle, or stroke days later, may be persuaded to believe that his illness is metaphysical. Rather than seeking *what* caused the illness, he may be concerned with *who* caused the illness. How this affects the ability of the patient to be fully autonomous is further discussed below.

The perception of illness highlighted above does not originate from the patient alone. John-Nwankwo asserts that there are several instances where physicians themselves suggest to a patient's family to take the patient home because his or her illness is spiritual. This might occur where the patient does not respond to treatment, or where, the patient looks physically ill and is in worsening pain, but diagnostic results show that he or she is healthy.

A study was carried out in Igbo-Ora, a town in south-western Nigeria, to explore accidents and unintentional injuries as a public health concern in Nigeria and to question the suitability of transferring to poorer countries strategies formulated in Western industrialized countries to combat them.⁵³⁹ The study found that except for diseases, such as malaria which is believed to have a simple natural cause, there is a common belief that death is rarely natural,⁵⁴⁰ and that diseases are caused by supernatural forces, including sorcery, witchcraft and 'spirit instruction.'⁵⁴¹ An earlier

Cultural Psychiatry" (2007) 10:3 Mental Health Religion and Culture 239. Other beliefs about illnesses include that some result from past evil doing, and that evil spirits could be appeased to cure mysterious illnesses.

⁵³⁹ RA Dixey, "Fatalism', Accident Causation and Prevention: Issues for Health Promotion from an Exploratory Study in a Yoruba Town, Nigeria" (1999) 14:2 Health Education Research: Theory and Practice 197.

⁵⁴⁰ See also Misty Laurette Bastian, *The World as Market Place: Historical, Cosmological, and Popular Constructions of the Onitsha Market System* (PhD Thesis, University of Chicago Department of Anthropology, 1992) [unpublished].

⁵⁴¹ Dixey, *supra* note 539 at 201.

study among Nigerian university students to evaluate their perception of death⁵⁴² showed that a majority thought that death, except in very old persons, and sometimes even then, was caused by “wicked people” or the gods. The students rarely thought that death would result from ill health, unavoidable accidents or other natural causes.⁵⁴³

How then does this impact on the informed consent process? The impact is perceived at two levels. On the first level, the question is whether such persons are competent to decide on their medical treatment. The second level is concerned with whether persons acting in accordance with such beliefs are autonomous. For the first level, two perspectives are offered. First, following the Supreme Court of Canada’s decision in *Starson v Swayze*, a patient need not accept that he or she has an illness for which he or she has been diagnosed or that the cause of it is as described by the physician. What is required is for the patient to acknowledge that he or she has the manifestations or symptoms of the illness. Based on this, provided the patient understands the treatment proposed for those symptoms and its implications, he or she is competent to accept or refuse treatment, notwithstanding his or her unorthodox belief.⁵⁴⁴ For example, where a patient understands the information disclosed by the physician for the symptoms which he or she has, even if he or she thinks there is another cause, he or she is competent to give or refuse consent to treatment, except where the illness causes him or her not to appreciate the condition.

It would seem, thus, that the duty of the physician is to ensure, in the abstract, that the patient understands his or her medical condition and the treatment proposed for that condition. It would also seem that the duty does not include convincing the patient about the cause of his or her condition and the necessity for the kind of treatment that is proposed. Where a patient understands, for example, that Paracetamol is an effective

⁵⁴² Shehu Ahmed Jimoh, “Nigerians’ Concept of Death and its Implication for Counselling” 8 *International Journal for the Advancement of Counselling* 75.

⁵⁴³ *Ibid* at 76.

⁵⁴⁴ *Starson v Swayze*, *supra* note 112.

drug for severe headache, but is not persuaded that the pounding in his or her head is a mere headache, he or she is nonetheless competent. And if he or she refuses to take Paracetamol because he or she fears that, being supernaturally caused, treating his or her “headache” through physical means might be dangerous, his or her decision would be respected.

Second, if we accept that the importance of informed consent or the values underlying informed consent are autonomy and the right of the patient to determine his or her treatment in line with his or her values, desires, experiences and belief, we would question a consent process that does not take into account the beliefs of the patient. We would ask: if informed consent aims to put the patient at the center of decision making about medical treatment, why is the emphasis on causes and treatments that do not cohere with his or her beliefs? In other words, why is disclosure centered around the perception of illnesses as caused by diseases or micro-organisms or technical failure, information that does not contribute to the patient’s perception of his or her health condition and which makes the consent process for him or her a mere formality?

Focusing on an abstract understanding by the patient of his or her medical condition and the treatment for it without engaging with the patient to understand his or her perception about the cause of his or her illness, arguably, anonymizes the patient. The physician presents only the natural or medical part of the illness, which is just one side of a holistic approach to medicine.⁵⁴⁵ This may cause the patient to “feel disempowered in the face of a foreign jargon, a strange story which, while it makes sense for the doctor, has little to do with the ground of his own life.”⁵⁴⁶ However, if we maintain our definition of competence as the ability to understand and appreciate the nature and

⁵⁴⁵ See Chapter Three where the elements of illness were indicated. The elements include the natural, supernatural, psychosomatic and psychosocial elements which operate together to form a holistic approach to medicine.

⁵⁴⁶ Lazare Benaroyo & Guy Widdershoven, “Competence in Mental Health Care: A Hermeneutic Perspective” (2004) 12 Health Care Analysis 295 at 302.

consequences of the decision that is to be made, then, despite the patient's belief, he or she is competent. Whether the patient is acting autonomously is discussed below.

At the second level, a meta-physical belief about causes of illness may be a product of the patient's socio-cultural environment which influences the decision that he or she makes. This is because, as argued under "Relationality of Autonomy", it is difficult to perceive of any thought, action or belief which is not socially caused. It may not be adequate to abandon a patient who refuses treatment out of such beliefs, nor would it be proper to impose treatment on him or her on the grounds that he or she is not acting autonomously. Rather, respect for the autonomy of a patient with such beliefs may require a physician to "respond sensitively to the meanings illness has for [the patient]; to deploy [his or her] power and influence to restore and strengthen autonomy competencies; and to support [the patient's] struggles to create new personal meanings out of the experience of disease, disorder or disability."⁵⁴⁷

Consequently, meeting the challenge posed by meta-physical belief about the causes of illness necessarily involves a hermeneutic approach which strives to build or enhance autonomous capacity through dialogue and intimate engagement with the patient.⁵⁴⁸ This hermeneutic approach represents an effective panacea to the several challenges to the practice of informed consent which involves understanding or cognitive effort such as religion and illiteracy. It may also help where the impediments to full exercise of autonomy is caused by socialization. For this particular challenge, a hermeneutic approach calls on the physician to listen to the patient without being patronizing or aloof, to tactfully draw out the patient's perspective about his or her illness, and, to engage with that perspective in a meaningful dialogue. This will enable both the physician and the patient to gain a higher appreciation of that perspective.

⁵⁴⁷ Donchin, *supra* note 520 at 240.

⁵⁴⁸ See generally Benaroyo & Widdershoven, *supra* note 546; Jennifer Clegg, "Practice in Focus: A Hermeneutic Approach to Research Ethics" (2004) 32 *British Journal of Learning Disabilities* 186.

5.1.5 Religion and Belief in Invincibility

In addition to belief that pathological conditions are not necessarily physical, Nigerians also generally accede to the idea that forces outside the individual control physical occurrences. As with meta-physical belief about causes of illness, the challenge that arises for informed consent is: whether a decision affected by this belief is nonetheless informed; and, whether the patient is acting autonomously.

The mindset about forces outside the individual reflects the religious belief systems in Nigeria. The two dominant religions are Christianity and Islam. Together, they account for about 90% of religious worship.⁵⁴⁹ However, neither Islam nor Christianity is free from mixture with indigenous beliefs in deities, spirits and ancestor worship⁵⁵⁰ which account for the remaining 10% of religious worship.⁵⁵¹

Belief in a supreme being who is supposed to have power to control both the dead and the living, and to influence human affairs, affects the way health information is received. For example, in the study referred to earlier on south-western Nigeria,⁵⁵² it was found that south-westerners have a basic belief in predestination, and this affects their philosophy and daily life.⁵⁵³ According to this belief, a person's fate is sealed at birth by

⁵⁴⁹ See Central Intelligence Agency, "The World fact Book" online: <https://www.cia.gov/library/publications/the-world-factbook/geos/ni.html>.

⁵⁵⁰ Ancestor worship is the belief that one's dead family member continues to live in the after-life and can influence events in the world of the living. This is similar to the belief of some faith communities, like the Catholic Church, which venerates those who are classified as saints, and which seeks the intercession of these saints for help in their worldly affairs.

⁵⁵¹ See Central Intelligence Agency, "The World fact Book" online: <https://www.cia.gov/library/publications/the-world-factbook/geos/ni.html>. See also "Countries and their Cultures" online: www.everyculture.com/Ma-Ni/Nigeria.html; www.kwintessential.co.uk/resources/global-etiquette/nigeria.html.

⁵⁵² Dixey, *supra* note 539.

⁵⁵³ Dixey, *supra* note 539 at 201.

Oludumare, the creator of life. This means that a person's destiny is already chosen for him or her, and he or she cannot deviate from it.

To find out what fate has in store, a person may consult *Orunmila*, the deity believed to be present when a person's fate was decided. This deity is consulted through a *babalawo*, who functions as the middle man or a go-between. Once a person does all that he or she is required by the *babalawo* to do, he or she believes that nothing can happen to him or her. As such, unless it has been divined to be so, he or she refuses to accept that he or she has the health condition the physician has diagnosed, or that he or she is at risk from a certain complication. Even where a misfortune is predicted, the south-western Nigerians believe that it can be averted by the sacrifice of, for example, a chicken.⁵⁵⁴ Dixey found that more people are turning to indigenous beliefs, and by extension, to religion for help in the face of collapsing faith in modern hospitals, economic decline and political uncertainty.⁵⁵⁵

The significance of this dependence on supernatural beings is that responsibility for failure, success, or good health is shifted from the individual to an abstract entity. This may be a coping mechanism to confront the challenges of declining economy, illiteracy and poor health.⁵⁵⁶ However, projecting power onto external forces reduces the individual's capacity to act logically and assertively. According to Tones *et al*, "a person who believes that life's choices are governed by the vagaries of fate or determined by a conspiracy of powerful others and faceless organizations will be less likely to mobilize the personal resources needed to face a potentially threatening situation."⁵⁵⁷ Informed consent aims to make the patient take charge of his or her own health and, consequently, his or her life, rather than leave it to the physician or to God.

⁵⁵⁴ See J Omosade Awolalu, *Yoruba Beliefs and Sacrificial Rites* (London: Longman, 1979).

⁵⁵⁵ Dixey, *supra* note 539 at 202.

⁵⁵⁶ Wande Abimbola, *Sixteen Great Poems of Ifa* (London: UNESCO, 1975).

⁵⁵⁷ Keith Tones, Silvia Tilford and Yvonee Keeley Robinson, *Health Education: Effectiveness and Efficiency* (London: Chapman & Hall, 1990) at 55.

It would seem that the imposition of this notion of individual responsibility in a culture where responsibility and fate is assigned to God, gods, or other entities, offends liberal values like respect for cultural sensitivity.⁵⁵⁸ It is argued that the emphasis placed on empowering individuals to take control of their lives and to direct it themselves, rather than see themselves as controlled by external factors, is at odds with another view that one cannot, nor is it desirable to take charge of one's destiny.⁵⁵⁹ On this latter view, if the gods will that a person would be sick or suffer any ill, it would come to pass. If, on the other hand, nothing of such nature has been destined, then it will not happen. In other words, whether risks connected to treatment occur or not is an act of God.

The effect on informed consent is that a Nigerian patient who is told that he or she has, for example, cancer may deny it: "God forbid! My body is the temple of the Holy Spirit and no cancer can live in me. I bind it and I cast it into hell!" Similarly, when risks of treatment are disclosed, he or she is likely to believe that "God will not let that happen to me. I am his child and he said healing is the children's bread." The challenge is whether consent obtained is informed. Where the patient refuses treatment because he or she has sacrificed a chicken, and believes that he or she is not destined to die from the illness, such a patient is competent if he or she understands and appreciates the implication of his or her decision, but is he or she acting autonomously?

The above question echoes an earlier one about whether persons who are influenced by a belief system to which they have been socialized are nonetheless acting autonomously and, if not, whether paternalism is justified in such cases. As well, the proper response may not be paternalism. Rather, it may be more appropriate, in enhancing and

⁵⁵⁸ See Donnelly, *supra* note 1 at 36. See also Leslie J Blackhall *et al*, "Ethnicity and Attitudes towards Patient Autonomy" (1995) 274 JAMA 820; Mahmut Alpertunga Kara, "Applicability of the Principle of Respect for Autonomy: The Perspective of Turkey" (2007) 33 J Med Ethics 627.

⁵⁵⁹ See Dixey, *supra* note 539 at 204. See also M Sidell, L Jones, J Katz & A Peberdy, *Debates and Dilemmas in Promoting Health* (Buckingham: Open University Press, 1997).

respecting the patient's autonomy to engage him or her in a dialogue concerning his or her beliefs in order to gain better insight into the patient's world view, and, if possible, to cajole, persuade or entreat him or her to make a decision that is anchored on his or her personal values, rather than on an abstract concept.⁵⁶⁰ Engaging a patient who refuses treatment because he or she has sacrificed a chicken, or because he or she believes in the healing power of faith in a frank and meaningful dialogue may cause the patient to reflect further on his or her refusal, and to make a decision that truly accords with his or her values. Perhaps, this will reduce the number of persons who refuse necessary treatment.

The next two cultural challenges are largely derived from the communal life in Nigeria. These challenges, discussed under familial influence in decision making, and sociology of respect and role play also affect the capacity of the patient to act autonomously. In other words, the discussion highlights the cultural constraints on the exercise of autonomy.

5.1.6 *Familial Influence on Decision Making*

The preceding factors show that Nigerian culture has a system of beliefs which are used to explain the etiology of illness. These beliefs affect proper evaluation and appreciation of a treatment option. In addition, there are cultural elements, other than the belief system, which also challenge the practice of informed consent. One of these is the influence of family on the medical decision that is made. Another is the stereotypical roles assigned to particular individuals or classes. These, as with the two preceding challenges, affect the extent to which a patient's decision is voluntary, and the extent to which the decision reflects his or her values. A patient's consent is required to be given voluntarily, and in the absence of any factor which overwhelms or undermines his or her will.

⁵⁶⁰ Religious belief may form part of the patient's personal values so that he or she may actually be acting in accordance with such values. However, he or she can still be reasoned with to change his or her mind, but he or she should never be compelled.

In Nigeria, as in many African countries, extended families are still the norm and in fact, the backbone of the social system.⁵⁶¹ Nigerians live in a culture that centers on the importance of family and the church. There are extended kinship bonds with grandparents, aunts, uncles, cousins, sisters, brothers, in-laws, and individuals who are not biologically related but who play an important role in the family system.⁵⁶² Individuals turn to members of the extended family for financial aid and guidance, and the family is expected to provide for the welfare of every member. Usually, a senior family member is consulted on important health-related decisions. Although the role of the extended family is diminishing in the urban areas of Nigeria, the tradition of mutual care and responsibility is still strong.

Unlike the above communal life in Nigeria where everyone is interconnected to others in various ways, the Western view of individuals is more individualistic. It assumes that each person is unique and highly knowledgeable about matters concerning him or her. As such, it is argued that each person, alone, should be able to voluntarily decide what happens to his or her body.⁵⁶³ The consequences of this atomistic assumption of individuality are two-fold: first, it sees patients not as passive individuals content to let their medical decisions to be made by the physician, but as active participants in the treatment process who determine the course of treatment based on their values and preferences.⁵⁶⁴ Second, it potentially suspects any influence on the patient's decision making, or adjudges such influence as overwhelming or undermining his or her will. This suspicion of undue influence is not limited to the conduct of physicians, but has

⁵⁶¹ www.kwintessential.co.uk/resources/global-etiquette/nigeria.html.

⁵⁶² www.kwintessential.co.uk/resources/global-etiquette/nigeria.html.

⁵⁶³ See Robert M Veatch, "Abandoning Informed Consent" (1995) 25 Hastings Center Report 5.

⁵⁶⁴ Monika JM Sahlsten, Inga E Larsson, Kaety AE Plos & C Lindencrona, "Hindrances for Patient Participation in Nursing Care" (2005) 19 Scand J Caring Sci 223.

increasingly widened to include the nature of pressure that family members exert on a competent patient's decision.⁵⁶⁵

Arguably, the influence of family members on the decision of a competent patient is suspected out of fear that they may have separate and conflicting motives for preferring one form of treatment to another, and that their preference may have nothing to do with advancing the patient's interest or promoting his or her wellbeing.⁵⁶⁶ Because of this fear, where a patient gives in to the persuasion of family members, the decision made may be assumed to be coerced or unduly influenced and, hence, not truly reflective of the patient's autonomy.⁵⁶⁷

An atomistic and isolated perception of patients denies the social context from which patients derive their identity.⁵⁶⁸ It also denies the influence of intimate relations, social obligations and group values which a person has internalized as part of the socialization process, and which contributes to shape his or her perception of himself or herself.⁵⁶⁹ Instead, the perception focuses on the individual as distinct, independent, and separated from others by clearly discernible boundaries which can only be crossed with the autonomous and uncoerced permission of the individual.⁵⁷⁰ The presence of such boundaries limits the treatments physicians can impose on patients without their consent, and requires that the consent given should flow freely from the patient as a moral agent.

⁵⁶⁵ See Jonathan M Breslin, "Autonomy and the Role of the Family in Making Decisions at the end of Life" (2005) 16 J Clin Ethics 11.

⁵⁶⁶ *Ibid.*

⁵⁶⁷ See for example, *Re T (Adult: Refusal of Medical Treatment)*, *supra* note 50.

⁵⁶⁸ Susan Sherwin, "A Relational Approach to Autonomy in Health Care" in Feminist Health Care Research Network, Susan Sherwin, coordinator, *The Politics of Women's Health: Exploring Agency and Autonomy* (Philadelphia, PA: Temple University Press, 1998) 19 at 34.

⁵⁶⁹ See Francoise Baylis, "The Self in Situ: A Relational Account of Personal Identity" in Jocelyn Downie & Jennifer J Llewellyn, eds, *Being Relational: Reflections on Relational Theory and Health Law* (Canada: UBC Press, 2012) 109.

⁵⁷⁰ Donchin, *supra* note 520.

Explanations offered for the near exclusive focus on patient autonomy include: (i) the general nature of illnesses and injury, described as “physically challenging and emotionally exhausting” for many patients, especially where the diagnosis and prognosis are unexpected or grim;⁵⁷¹ (ii) patients are often in a vulnerable position in relation to the physician and are, therefore, prone to manipulation and coercion;⁵⁷² (iii) while physicians, family and other persons may have vested interests in the health of the patient, it is the patient who, ultimately, must live with the consequences of any decision. Hence, it is proper that his or her preference be controlling.⁵⁷³

This does not suggest that the involvement of family members in the decision making process has always been frowned upon. Family members have been involved in providing care for the patient through the illness, conveying his or her wishes to the physician or explaining the physician’s instructions to him or her, and caring for him or her while he or she recuperates.⁵⁷⁴ Where family involvement leads to challenging the physician’s professional judgment, or where it interferes with the patient’s decision making, it may lead to a finding that the involvement overrode the patient’s autonomy and is undue influence.⁵⁷⁵ Accordingly, where patients defer to the opinion of their family members or take into significant consideration their wishes, desires and values *and* so make a decision that is contrary to the physician’s judgment, such patients may

⁵⁷¹ Anita Ho, “Relational Autonomy or Undue Pressure? Family’s Role in Medical Decision-Making” (2008) 22 Scand J Caring Sci, 128 at 129.

⁵⁷² Jonathan M Blustein, “The Family in Medical Decision Making” (1993) 23 Hastings Center Report 6; Catherine A Chesla & David E Stannard “Breakdown in the Nursing Care of Families in the ICU” (1997) 6 Am J Crit Care 64.

⁵⁷³ Ho, *supra* note 571 at 129.

⁵⁷⁴ Blustein, *supra* note 572; Ing-Mari Soderstrom, Eva Benzien & Britt-Inger Saveman, “Nurses’ Experiences of Interactions with Family Members in Intensive Care Units” (2003) 17 Scand J Caring Sci 185.

⁵⁷⁵ See Blustein, *ibid*; Chesla & Stannard, *supra* note 572.

be assumed to be unduly influenced, and their decisions may be assumed not to reflect their desires as autonomous individuals.⁵⁷⁶

Autonomy is best protected when the patient retains control of his or her treatment decision. As earlier discussed under “Trust”, the reality of illness, and the nature of dependence and vulnerability which it excites determine the extent to which patients are willing to retain decision-making power.⁵⁷⁷ Studies show that patients vary in the level to which they desire to participate in their healthcare decision: while some want to fully participate in the decision-making process, others are comfortable with letting their family members decide, and others take into account, the opinions of family members in reaching a decision.⁵⁷⁸

The decision made may impact on familial relationships financially, emotionally and psychologically. In turn, this may affect the decision that the patient makes. For example, whether a patient chooses to withdraw life-saving treatment may be influenced by the costs to his or her family – the emotional cost of providing long term care for him or her, perhaps at the expense of other commitments; the financial cost of treatment, especially where finances are limited; and psychological dread that another sibling may have to leave school to save resources for his or her treatment.⁵⁷⁹ These are constitutive factors that may weigh on a patient’s decision. Do these factors constitute undue influence?

⁵⁷⁶ Perhaps if the patient in *Re T* had accepted blood transfusion, her decision would have been respected not minding that she spent time with her mother who might have influenced her decision.

⁵⁷⁷ George J Agich “Reassessing Autonomy in Long-Term Care” (1990) 20 *Hastings Centre Report* 12.

⁵⁷⁸ See for example, Deborah L Volker, “Control and End-of-Life Care: Does Ethnicity Matter?” (2005) 6 *Am J Hosp Palliat Care* 442; Henry S Perkins et al, “Cross-Cultural Similarities and Differences in Attitudes about Advance Care Planning” (2002) 17 *J Gen Intern Med* 48; Claretta Yvonne Dupree, “The Attitudes of Black Americans Toward Advance Directives” (2000) 11 *J Transcult Nurs* 12.

⁵⁷⁹ See Dapa A Diallo *et al*, “Community Permission for Medical Research in Developing Countries” (2005) 41 *Clinical Infectious Diseases* 255.

If we adopt the predominant Western individualism, then we may affirm that the above factors are external influences on the patient's decision making. However, such external influences may not always amount to undue influence, especially in a communal society like Nigeria. The reflection and thought process leading to a particular decision may take into account several factors and persuasions around which the final decision is based. Unless these factors can be said to have overwhelmed or undermined the will of the patient, the patient's decision is, arguably, autonomous.

It may not be as easy to classify situations where the decision is made for the patient by other persons. Would communal living and relational account provide justification for such a decision making structure? This is further discussed below. The discussion is split into two: the first and immediate part explores how, acknowledging the relatedness of individuals in Nigeria, it is not unusual for familial influences to exist, or for familial interest and opinion to be taken into account. The second part discusses the validity of assigning decisional authority to another person, where the patient is competent, for reason only that the patient is a female. This second part highlights issues of gender inequality and patriarchy in Nigeria.

5.1.6.1 Familial Influence: A Relational Account

Acknowledging that Nigeria is largely communitarian presupposes that an individual is made up of all the relationships he or she has fostered through life and this includes his or her family.⁵⁸⁰ Within this set up, a patient's actions influence and are influenced by the relationships. This does not necessarily subsume his or her will, for he or she is still free to incorporate or reject the influences of a group into what he or she perceives to be his or her own values fostered through the relationships he or she has with other people.⁵⁸¹

⁵⁸⁰ See generally, Baylis, *supra* note 569.

⁵⁸¹ See the President's Commission Report, *supra* note 22 at 46.

Therefore, a patient who has been nurtured and socialized into being considerate to other members of the family, and cares for them especially in material terms, may accept a course of treatment, or no treatment, in order to cause the least suffering to his or her family. On the other hand, this value might not be very pronounced in a person who was socialized to think first or only of himself or herself, or who repudiates the feeling of guilt at the cost to his or her family of his or her treatment decisions. The thoughtful consideration, or repudiation of the effect of his or her decision on his or her family, serves to highlight his or her values and enables him or her to make decisions which accord with those values.

A relational identity recognizes that:

Illness is not an isolated or time-limited event, but a highly stressful situation that evolves from the family's history and contributes dynamically towards its future. Patients in tight-knitted families, particularly in certain ethnic ... groups, do not see themselves as independent units. Rather they often discuss their conditions with or are cared for by family members long before seeking professional help. Unlike institutional medicine, familial care relationships are not generally based on temporary contracts but on empathy and beneficence family members have towards one another.⁵⁸²

In a setting like the above, to insist that the patient, mentally or physically, distances himself or herself from this relational identity is to insist that he or she cuts himself or herself off from his or her family and to work against their care for him or her.⁵⁸³ This is especially so, given that rather than autonomous decision making, a patient may be more interested in preserving his or her identity and relationship with others who understand and share his or her history, experiences and story. This view is primarily set on the assumption that family members truly care about the patient's interest and wellbeing.

⁵⁸² Ho, *supra* note 571 at 130.

⁵⁸³ See Wim JM Dekkers, "Autonomy and Dependence: Chronic Physical Illness and Decision-Making Capacity" (2001) 4 *Med Health Care Philos* 185.

Contrary to this enmeshment within a relational context as part of undergoing treatment is the situation where the patient's agency is replaced by that of his or her family members. The import of this substitution for informed consent in Nigeria is considered next.

5.1.6.2 Familial Influence: Substituted Decision

In a second sense, family may actually hinder autonomous decision making by the patient. This contemplates instances where rather than the patient making the decision while considering the family situation, or validly delegating decisional power to a family member, the decision is made by another member of the family, for example, a husband, father or brother, by reason of his gender. Nigeria is a patriarchal society where cultural and religious norms perpetuate ingrained inequalities between the sexes.⁵⁸⁴ Women, compared to men, are accorded subordinate status by custom, in the family, the economy and the polity.⁵⁸⁵

The culture of patriarchy is passed on from one generation to the next and endures by virtue of socialization, internalization and acceptance.⁵⁸⁶ By socialization, a female is born into a status of inequality because of her gender.⁵⁸⁷ She is taught from an early stage that she is different from a male, not only in terms of physical anatomy, but in

⁵⁸⁴ Nigerian NGO Coalition on CEDAW, "CEDAW and Accountability to Gender Equality in Nigeria: A Shadow Report 2008" Report for the Forty First (41st) Session of the Committee on the Elimination of All Forms of Discrimination Against Women.

⁵⁸⁵ Bolatito Lanre-Abass, "Autonomy and Interdependence: Quandaries in Research Ethics" (2012) 4:4 Health 173 at 177.

⁵⁸⁶ Fitnat Naa-Adjeley Adjetey, "Reclaiming the African woman's Individuality: The Struggle between Women's Reproductive Autonomy and African Society and Culture" (1994-1995) 44 Am U L Rev 1351; Lanre-Abass, *ibid*.

⁵⁸⁷ Hamisa Omari Mwenegoha, *Women's Reproductive Rights and Autonomy under Islam as they Intersect with Human Rights Entitlements and Customary Norms and Practices in Tanzania-Lushoto as a Case Study* (LLM Thesis, Women's Law Southern and Eastern African Regional Centre for Women's Law (SEARCWL) Faculty of Law University of Zimbabwe, 2008) [unpublished].

expectations, behaviour and roles. Over time and with continued socialization, these gender differences, behaviour and roles are internalized. Following internalization, the gender roles, inequality and male dominance are severally accepted as normal and natural states of affairs.⁵⁸⁸ The females, in turn, pass the same message to their own female children. As a consequence, the suppression of women's rights and autonomous capacity are accepted or excused as part of Nigerian culture.⁵⁸⁹

One cultural norm which enjoys statutory backing is the right given to a man to beat his wife in order to correct her, provided that he does not cause permanent physical injury to her.⁵⁹⁰

As a patriarchal society, decision making, including in relation to healthcare, is often the preserve of the man who is the authority figure of the family, especially where the economic strength of the family depends on him. An aspect of women's healthcare decision making which is particularly constrained by patriarchy is reproductive health and rights. As used here, "reproductive right" includes reproductive autonomy and refers to the right and entitlement, in law and in fact, of women to control every aspect of their reproductive lives, such as whether or not to have children, the number and spacing of children, whether or not to use contraceptives, including the kind of contraceptive to use, and whether or not to carry a pregnancy to term. To exercise their reproductive rights, women need reproductive autonomy. However, there is a general reluctance to acknowledge the reproductive autonomy of women in Nigeria.⁵⁹¹ It is

⁵⁸⁸ Mwenegoha, *ibid.*

⁵⁸⁹ See Rebecca J Cook, "International Protection of Women's Reproductive Rights" (1992) 24 NYU J Int'l L & Pol 645 at 655 (on how culture is used to hold women captive to their reproductive function).

⁵⁹⁰ *Penal Code* s 55(1)(d). This Statute applies in all the 19 states of Northern Nigeria and in the Federal Capital Territory, Abuja.

⁵⁹¹ See generally Adjetey, *supra* note 586.

suggested that one cultural factor that is responsible for this is the payment of bride price which objectifies women and makes them chattels owned by men.⁵⁹²

The implication of this patriarchal setting is that all her life, a woman remains under the custodianship of her father, husband, or eldest son, as she progresses from childhood through marriage and widowhood and finally to old age. She is socialized not to refuse to have sexual relations with her husband.⁵⁹³ She is also under societal pressure to get pregnant, and to have children, preferably male children. This is true in Southern and Northern Nigeria. In Northern Nigeria, after marriage, a woman is expected to be largely invisible to outsiders and under the authority of her husband's family. She has little say in domestic decisions and even less freedom of movement. Her prestige and security in her husband's home depends on her ability to bear children, and particularly, the number of sons she bears.⁵⁹⁴

Similarly, a woman, especially a married woman, may not unilaterally decide not to carry a pregnancy to term without risking the break-up of her marriage. This is partly due to the fact that abortion is still illegal in Nigeria, with a maximum of a 14 year jail term for its provider, and 7 years for the woman, unless carrying the pregnancy to term would jeopardize her life⁵⁹⁵ or her physical and mental health.⁵⁹⁶ It is also due to the

⁵⁹² See Lanre-Abass, *supra* note 585 at 177; Adjetey, *supra* note 586 at 1352.

⁵⁹³ Beatrice Akua Duncan, "Marital Rape as a Form of Domestic Violence and the Need for Law Reform in Ghana" (LLM thesis, Georgetown University Law Center, 1994) [unpublished].

⁵⁹⁴ S J Jejeebhoy and ZA Sathar, "Women's Autonomy in India and Pakistan: The influence of Religion and Region" (2001) 27 Population and Development Review 687.

⁵⁹⁵ See *Criminal Code Act* Cap 77 Laws of the Federation, 1990 s 297. See also *Penal Code* s 235.

⁵⁹⁶ See *Rex v Bourne* [1939] 1 KB 687 (Ireland); Boniface A Oye-Adeniran, Carolyn M Long & Isaac F Adewole, "Africa: Advocacy for Reform of the Abortion Law in Nigeria" (2004) 12(24 Suppl) Reproductive Health Matters 209. Although it appears that women with the means to do so, may still obtain abortion services from the private sector. See Akinrinola Bankole et al, "Unwanted Pregnancy and Induced Abortion in Nigeria: Causes

cultural belief that a married woman lacks the autonomy to terminate a pregnancy; the religious belief that children come from God and one has no right to terminate life;⁵⁹⁷ and the fear that a relaxed position on abortion would encourage female promiscuity.⁵⁹⁸

However, the illegality of abortion and the societal stigma that it engenders has not affected the high incidence of abortion in Nigeria. Rather, it has increased the rate of unsafe abortions and, consequently, the rate of maternal mortality.⁵⁹⁹ Available statistics suggest that:

Unsafe abortion is a major cause of maternal mortality and morbidity in Nigeria, accounting for 30–40% of maternal deaths. The abortion rate in Nigeria is 25 per 1000 women aged 15–44 years and there are about 610,000 pregnancy terminations annually. About 60% of these are in young women, mainly carried out by unskilled practitioners. However, the fact that 60% of terminations in Nigeria are still being done by unskilled providers, using unsafe methods like dilatation and curettage, a range of often harmful and ineffective drugs and insertion of solid or sharp objects into the cervix to perform abortions, suggests

and Consequences” (2006) <https://www.guttmacher.org/pubs/2006/08/08/Nigeria-UP-IA.pdf>.

⁵⁹⁷ Oye-Adeniran, Long & Adewole, *ibid*.

⁵⁹⁸ According to the Population Policy Data Bank maintained by the Population Division of the Department for Economic and Social Affairs United Nations Secretariat, a 1982 attempt to liberalize abortion law in Nigeria was defeated. A termination of pregnancy bill, sponsored by the Society of Gynecologists and Obstetricians of Nigeria, was presented to the National Assembly. The bill would have permitted abortion if two physicians certified that the continuation of a pregnancy would involve risk to the life of the woman, or cause physical and mental injury to her or to any existing children in her family to a greater extent than if the pregnancy was terminated. The bill would also have allowed abortion if “there was a substantial risk that the child, if born, would suffer such physical and mental abnormalities as to be seriously handicapped”. Abortions performed on these expanded grounds could have been carried out only in the first 12 weeks of pregnancy, except to save the life of the woman. The bill also would have permitted physicians to refuse to perform an abortion on grounds of conscience. The bill was strongly opposed by religious leaders and by the Nigerian National Council of Women’s Societies of Nigeria, who feared that its passage would promote sexual promiscuity. The abortion law has remained unchanged to date. For a detailed and comprehensive discussion of unwanted pregnancy in Nigeria see Bankole et al, *supra* note 596.

⁵⁹⁹ See *ibid*.

a high post abortion complication rate. These high levels of morbidity and mortality could be prevented by improving access to contraceptive services, sexuality education, safe abortion procedures and treatment for abortion complications.⁶⁰⁰

The above indicates that women die because they want to make decisions concerning their own bodies which both the government and society will not let them do safely. Denying women access to safe abortion, except where the life of the woman is in jeopardy, forces women to have babies, even when they are financially, emotionally, psychologically and even physically incapable or unready to take care of the child. This constitutes a violation of their reproductive autonomy and right.⁶⁰¹

Accordingly, the woman is trapped from every angle: while she cannot refuse sexual relations with her husband, she cannot also access contraceptive treatment without his consent. As well, she cannot decide not to carry the pregnancy to term, and the birth of a female child is received with less enthusiasm than that of a male child.⁶⁰² More than these, she may not be able to discuss her sex-related predicaments so as not to incur societal ridicule.⁶⁰³ Although particularly visible in the area of reproductive health, the

⁶⁰⁰ Oye-Adeniran, Long & Adewole, *supra* 596 at 210. See also I Okagbue, "Pregnancy Termination and the Law in Nigeria" (1990) 21:1 Studies in Family Planning 197; FE Okonofua et al, "Assessing the Prevalence and Determinants of Unwanted Pregnancy in Nigeria" (1999) 30:1 Studies in Family Planning 67; BA Oye-Adeniran, AV Umoh & SNN Nnatu, "Complications of Unsafe Abortion: A Case Study and the Need for Abortion Law Reform in Nigeria" (2002) 10:19 Reproductive Health Matters 18; IF Adewole et al, "Contraceptive Usage among Abortion Seekers in Nigeria" (2002) 21:2 West African Journal of Medicine 112.

⁶⁰¹ See the US case of *Roe v Wade* 410 US 113 (1973) where the court held that a woman, guided by the medical judgment of her physician, had a "fundamental" right to abort a pregnancy, a right the Court anchored to a concept of personal autonomy derived from the due process guarantee.

⁶⁰² Adjetey, *supra* note 586 at 1358. See also Centre for Islamic Legal Studies, Ahmadu Bello University Zaria, "Promoting Women's Rights through Sharia in Northern Nigeria" (www.ungei.org/resources/files/dfid_promoting_women's_rights.pdf).

⁶⁰³ Adjetey, *ibid* at 1357.

impediment to women's autonomy transcends their reproductive health and extends to their general health care decision making.

In a 2011 survey by Demographic Health Survey on women's participation in different aspects of household decisions, it was found that women in the African countries surveyed generally lack the power to make decisions about their own healthcare. In particular, it was found that for over 70% of women in Nigeria, Burkina Faso and Malawi, their husbands alone make their healthcare decisions.⁶⁰⁴ One reason for this is economic. According to Kola' Oyediran and Ayodele Odusola:

The focus of household decision-making is determined by who controls and allocates economic resources within the family. A change in income generating capacity of partners precipitates a change in household decision-making prerogatives. Thus, at the core of household decision-making determinants is poverty. An important determinant of poverty, on the other hand, is low women participation in decision-making at home and in the community.⁶⁰⁵

In other words, the capacity of a female to participate in decision making is dependent, among other variables, on her financial strength.⁶⁰⁶ However, it is contended that in Northern Nigeria, irrespective of a wife's educational attainment or occupational position, decisions are generally made by the husband.⁶⁰⁷

⁶⁰⁴ UNDP, African Women's Rights Observatory (www.awro.uneca.org/QuantitativeAnalysis.aspx).

⁶⁰⁵ Kola' A Oyediran & Ayodele F Odusola, "Poverty and the Dynamics of women's Participation in Household Decision-Making in Nigeria" African Population Studies Supplement A to vol 19 at 116. See also I O Orubuloye, F Oguntimehin & T Sadiq, "Women's Role in Reproductive Health Decision Making and Vulnerability to STD and HIV/AIDS in Ekiti, Nigeria" (1997) Suppl to vol 7 Health Transition Review 329.

⁶⁰⁶ For a detailed discussion of the dynamics of women's participation in household decision making in Nigeria, see Kola' A Oyediran & Ayodele F Odusola, "Poverty and the Dynamics of women's Participation in Household Decision-Making in Nigeria" African Population Studies Supplement A to vol 19.

⁶⁰⁷ See Lawal *et al*, *supra* note 10.

The decision-making authority of the husband in Northern Nigeria stems from his obligations in the Qur'an.⁶⁰⁸ These obligations include to love and cater for the needs of his wife, including her healthcare needs.⁶⁰⁹ In turn, the obligation of the wife includes devout obedience, conscientious guarding of her chastity, contributing to the success of the marriage, taking care of the comfort and wellbeing of her husband, and avoiding conducts that may offend him.⁶¹⁰ Because the husband has to maintain his authority over his wife, he does not consult her before making decisions.⁶¹¹ Conversely, in keeping with her obligation of devout obedience, and in order not to offend her husband, the wife complies with the decision he makes.

As indicated above, decision making in the context of healthcare presents two possible arguments. On the one hand, it may be argued that the decisional authority of the patient and, consequently, her autonomy in this respect is significantly diminished if she is not allowed to make decisions herself. For, decision making must proceed from a competent patient or her appointee as a free and autonomous agent. Therefore, to impose another person's treatment decision on her does not respect her autonomy and does not satisfy the requirement of voluntariness in informed consent.

On the other hand, if we adopt the view of the husband and wife as a unit, unified by matrimony, and so, not separate autonomous persons, then we might accept the husband's decision as flowing from the unit and not from the husband as a separate

⁶⁰⁸ The Qur'an is the central religious text of Islam and is considered by Muslims to be the verbatim word of God. See Seyyed Hossein Nasr "Qur'an" [2007] Encyclopaedia Britannica Online: (www.britannica.com/EBchecked/topic/487666/Quaran).

⁶⁰⁹ Centre for Islamic Legal Studies, Ahmadu Bello University, Zaria, "Promoting Women's Rights through Sharia in Northern Nigeria" (2004) online: (www.ungei.org/resources/files/dfid_promoting_womens_rights.pdf) at 8.

⁶¹⁰ *Ibid.*

⁶¹¹ *Ibid* at 14 and 15. A recent study found that over 90% of married girls in northern Nigeria report that healthcare decisions are taken by their husbands and without consulting them. See Annabel S Erulkar & Mairo Bello, "The Experience of Married Adolescent Girls in Northern Nigeria" [2007] Population Council Online: (www.popcouncil.org/pdfs/Nigeria_Married.pdf).

individual. In this sense, it would not matter who the actual decision maker is, or the processes leading to the decision. Provided the decision follows an understanding of the nature of treatment and its risk, it is validly made and the autonomy of the unit is not harmed. Looked at from another angle, it could be said in this context that since the rights and obligations of the husband and wife are accepted by either party, so that the obligations of the husband give the wife a right in their performance, and the obligations of the wife give the husband a right in their performance, it would seem that the wife has a right to expect the husband to provide her needs, including healthcare needs. Doing this may include deciding what healthcare needs should be provided or received, and when. Correspondingly, the husband has a right in the devout obedience of his wife and this, by extension, includes obedience to his decisions. On this view, the autonomy of the wife-patient is arguably undisturbed, being that she is getting what, in a manner of speech, she bargained for.

It may also be argued that the rights and obligations of husbands and wives as provided by the Qur'an, serve identical functions with a waiver. In this case, the wife waives decisional authority in favour of her husband and undertakes to comply with his decisions. In regard to waiver, the waivor retains the right to reclaim the right to decide, but this does not seem possible in the circumstances here where unflagging obedience has been promised and can even be compelled by physical measures.⁶¹²

The import of the foregoing is that obtaining first-person consent may be problematic. There is suggestion that it is perfectly acceptable and culture-respecting to obtain consent from the husband of a competent woman.⁶¹³ Perhaps this suggestion is based on a fear that to insist on first person consent may disrupt the marital relationship, and perhaps, create more problems for the patient. But, respecting such cultures may be validating gender inequality and the subordinated status of women. Consequently, it

⁶¹² See *Penal Code* s 55(1)(c) where a husband is allowed to beat his wife to correct her.

⁶¹³ See Irabor and Omonzegele, *supra* note 10 at 40.

may be ideal to disrupt certain relationships if they are oppressive. Seeking first person consent is particularly important in patriarchal Nigeria for the very purpose that it should disrupt such unequal relationships.⁶¹⁴ How to go about getting first person consent is another challenge. This follows the internalization and acceptance of their subordinated status which makes some women seek permission from their husbands before consenting to treatment, in situations where physicians attempt to deal directly with them.⁶¹⁵ It is not certain that physicians alone can effectively meet this challenge. However, they can certainly contribute by tactfully bringing the patient into the treatment discussion and asking for their suggestions, contribution and preference. In the long run, greater improvement may come through economically and educationally empowering women.

Another challenge to informed consent in Nigeria which affects the exercise of autonomous capacity is the culture of role play. This stems from an emphasis given to hierarchy which maintains inequality in the Nigerian culture. Markers of this inequality include age, social and economic standing. This challenge affects mostly women and children. This challenge is discussed immediately below.

5.1.7 *Sociology of Respect and Role Play as a Challenge to Informed Consent in Nigeria*

So far, this chapter has argued that informed consent may be constrained where (i) the patient is cognitively misaligned with the physician either as a result of unorthodox belief either as to the cause of his or her illness or metaphysical belief in his or her imperviousness to the risks of the illness or its treatment, and (ii) the patient has the

⁶¹⁴ See Friedman, *supra* note 19 at 46 (on how autonomy is important for women in patriarchal conditions partly because of its disruptive potential).

⁶¹⁵ Ezeome & Marshall, *supra* note 10. However, this is not the case for all women, especially women who are educationally and economically strong.

capacity, but is unable to exercise his or her right of autonomy. It has demonstrated that this may arise in a number of ways, such as where, owing to patriarchy, a woman is not allowed to make her decision. Another constraint on the exercise of autonomy derives from the Nigerian emphasis on hierarchy and stratification with definite roles assigned to each stratum.

Nigeria is a hierarchical society where age, position and wealth demand respect.⁶¹⁶ This means that the lack of equality between individuals is acknowledged and accepted without question. It also means that there is a general recognition of the roles each person is expected to play based on the person's status or position. For example, there is a general recognition of inequality between government and governed, between employers and employees, between teachers and students, between parents and children and, between physicians and patients.

Along with this recognition is the expectation that each class of persons would fulfill the roles designated to their class. The government is expected to provide basic needs: social, economic, healthcare, educational, infrastructural and related resources. Employers are expected to provide jobs, good staff packages and safe working environments. Parents must provide for their children, including determining the nature of healthcare treatment they would receive.⁶¹⁷ For physicians, it is expected that they are knowledgeable about the human anatomy, about detecting what health problem a patient has, and that they can be trusted to act beneficently to relieve the patient of that health problem. Thus, inequalities are accepted and those in subordinate positions trust the superordinate classes to carry out their roles. For those in the subordinate

⁶¹⁶ www.kwintessential.co.uk/resources/global-etiquette/Nigeria.html.

⁶¹⁷ See Rose Ndakala Oronje *et al*, "Operationalizing Sexual and Reproductive Health and Rights in Sub-Saharan Africa: Constraints, dilemmas and Strategies" (2011) BMC International Health and Human Rights (<http://www.biomedcentral.com/1472-698X/11/S3/S8>) (stating that parents often constitute hindrance to adolescents accessing sexual and reproductive health information and services).

group, such as the governed, students, employees and patients, it is expected that they should be told what to do.⁶¹⁸

Given the foregoing, it is not surprising that informed consent which, in effect, challenges the superordinate position and role of physicians, has not received full compliance. Although there have been, at least, two reported cases that seem to endorse a patient's right to refuse treatment on religious grounds, these cases could be seen to not have fundamentally challenged the expectation that physicians know what is best for the patient and that their duty is to benefit the patient. One way of analyzing the cases, is to see them as endorsing respect of another unequal relationship, one which is regarded as higher than that between the physician and the patient. That is, the unequal relationship between the Creator, God, and his creatures. The decision calls for respect for God's command to his creatures not to eat blood and blood products. This decision does not affect the role assigned to any class. Rather, it affirms that a higher class requires a certain conduct, the lower class must, of necessity, defer to the wishes of the higher class.

The foregoing may be exemplified thus: Given the inequality in relationships between government and governed, doctor and patient, teacher and student, parents and children, pastor and congregation, where there is conflict between a stipulation by government that everybody must stay at home on a particular day, and an instruction by a teacher that classes would hold on the same day, because the relationship between government and the teacher is also one of inequality, with the class of teachers being the subordinate, the student is more likely to comply with the requirement of government. This does not translate to denying the role of teachers to hold classes, but it affirms their subordination to the superior authority of government.

⁶¹⁸ See generally Geert Hofstede's 5-Dimension Cultural Model in Geert Hofstede, *Culture's Consequences: International Differences in Work Related Values* (Beverly Hill: Sage, 1980).

In sum, the culture of role play has not been unsettled by the courts in *MDPDT v Okonkwo* and *Esabunor v Faweya*. By implication, this says that in Nigeria, the prevailing notion and expectation is that a patient is content to play the role of a patient and to allow the physician to play her role of carrying out her care. Clearly, this means a patient may not necessarily expect to be asked to consent to a course of treatment decided upon by the physician as appropriate for his or her care, and the physician would expect the patient's agreement with his or her decision, and compliance with his or her instructions.

But, a patient is a morally accountable agent who is responsible for his or her actions. When a patient acts on the basis of a role assigned to him or her, the intuition that they are not autonomous may be triggered. It is possible that though possessing the power to reflect, regulate and control his or her behavior, in the light of his or her values and beliefs, the patient may choose not to exercise it. In this case, his or her submission to a physician's instruction is, arguably, an exercise of autonomy.

However, in situations where the patient does not critically and reflectively choose the role he or she is assigned, either because he or she is unaware that he or she has a choice whether or not to carry out his or her assigned role, his or her autonomy is, arguably, impeded. A patient who, in asserting his or her autonomy, refuses to passively accept the role that is expected of him or her may create friction or disrupt the relationships that are built around those obligations and expectations. However, as mentioned earlier, the disruptive effect of autonomy is only a possibility, not a necessary outcome of the exercise of autonomy. Accordingly, it should not detract from the desirability of full exercise of autonomy.

The next two challenges to informed consent derive from contextual differences between Nigeria and other jurisdictions with a more robust consent law and practice. Beginning first with cultural relativism, it shows that, as currently construed, informed

consent arose from and is tailored to fit western countries. As a result, attempting to practice informed consent in Nigeria without first domesticating it creates avoidable challenges. The second contextual difference focuses on how the absence of judicial compulsion removes the incentive to faithfully adhere to informed consent requirements.

5.1.8 *Cultural Relativity as a Challenge to Informed Consent in Nigeria*

Distilled from all of the foregoing is that while there are globally cognizable challenges to informed consent, there are those that are more likely than others to exist in a particular society. Although the concept and appeal of autonomy is recognized in all cultures, its expression may vary according to the particular culture that is being observed. This makes it incongruous to interpret autonomy uniformly across various cultures.

Nigeria is a unique legal system in which certain western-developed concepts may serve to frame practices. Unless such concepts are made to fit the background, experiences and values of its people, they are likely to be irrelevant to the issues they seek to frame. Challenges to informed consent caused by variations in culture are noted by several authors.⁶¹⁹ Each element of informed consent has implications for different cultures. For example, full disclosure may conflict with cultural beliefs about hope and wellness; strictly autonomous decisions may conflict with family centered decision making and the social meaning of competence; uncoerced decisions may conflict with cultural

⁶¹⁹ For example, Joseph A Carrese & Lorna A Rhodes, "Bridging Cultural Differences in Medical Practice: The Case for Discussing Negative Information with Navajo Patients" (2000) 15 J Gen Intern Med 92; RJ Levine, "Informed Consent: Some Challenges to the Universal Validity of Western Model" (1991) 19 Law Med Health Care 107; Lawrence O Gostin, "Informed Consent, Cultural Sensitivity and Respect for Persons" (1995) 274 JAMA 844.

norms of obedience to the wishes of one's spouse or family elders.⁶²⁰ A culturally sensitive approach to healthcare may achieve better outcomes.⁶²¹

As currently framed in the literature, informed consent as a concept, suggests that the inequality between physicians and patients is so worrisome that it needs to be exchanged for one which balances such inequality. This view of informed consent accords and coheres with some societies in which it is practiced - like Canada, US, UK, and Australia. In these societies, there is a common desire to erase the inequality between physicians and patients and to push for patient sovereignty and self-determination. This desire is not readily found in Nigeria. The seminal research by Geert Hofstede sums up this relativist reality thus: culture is relative and not universal.⁶²²

5.1.8.1 Exploring Cultural Differences through Hofstedian Analysis

Culture refers to a set of distinctive spiritual, material, intellectual and emotional features of society or a social group, including art and literature, lifestyles, ways of living together, value systems, traditions and beliefs.⁶²³ It is usually acquired and transmitted over generations by symbols, stories and rituals. Culture may be said to be learned, shared, cumulative, symbolic, integrated and above all, dynamic. Arguably, a person's

⁶²⁰ Levine, *ibid*; Ezeome & Marshall, *supra* note 10.

⁶²¹ See Carrese & Rhodes, *supra* note 619.

⁶²² Geert Hofstede, *Culture's Consequences: International Differences in Work Related Values* (Beverly Hill: Sage, 1980). Hofstede's work has been criticized on several grounds including the method used in the research, delineation of culture by nations, assumption of cultural homogeneity within a nation, relevancy in modern time, too few dimensions. See, for example, Brendan McSweeney, "Hofstede's Model of National Cultural Differences and their Consequences: A Triumph of Faith – A Failure of Analysis" (2002) 55 *Human Relations* 89; Ercan G Nasif, Hamad Al-Daeaj, Bahman Ebrahimi & Mary S Thibodeaux, "Methodological Problems in Cross-Cultural Research: An Update" (1991) 31:1 *Management International Review* 79; Karen L Newman & Stanley D Nollen, "Culture and congruence: The fit between management practices and national culture" (1996) 27:4 *Journal of International Business Studies* 753. For Hofstede's response to some of the criticisms, see Geert Hofstede, "Attitudes, Values and Organizational Culture: Disentangling the concepts" (1998) 19:3 *Organization Studies* 477.

⁶²³ UNESCO 2002.

culture influences his or her perception or interpretation of reality; and, perception is seen as experience filtered through one's cultural background. The same event may be interpreted differently by people from different cultural backgrounds.

Geert Hofstede developed five dimensions by which to measure the cultural relativity of various countries and to compare them with one another.⁶²⁴ Four of the five dimensions or perspectives are: (i) the extent to which power inequality is accepted; (ii) the degree to which the country values certainty; (iii) the prevailing notion of the self; and (iv) the nature of the drive in society. These perspectives are conceptualized respectively as Power Distance, Uncertainty Avoidance, Individualism/Collectivism, and Masculinity/Femininity.⁶²⁵

From Hofstede's analysis, a society characterized by a comparably high power distance accepts, to a larger extent, class inequality in hierarchical relationships. Persons in this society generally accept their place on the class strata. To a large extent, such a society does not debate the idea that some should lead others or that certain privileges belong to powerful and influential persons and there is a less active pursuit of participatory encounters. Rather, people tend to accept that those in authority should decide and direct what should be done. There is also no general expectation of input from persons who belong in the lower stratum of the unequal relationship. Rather, these persons are limited to carrying out the instructions given. In such societies, decision making authority is centralized. Hofstede finds, with a score of 80, that Nigeria is a very hierarchical society. It is more hierarchical than South Africa which has a score of 49. In societies with a lower level of power distance, for example UK (35), Australia (36), US (40) and Canada (39), inequality in power distribution is rejected and justification is demanded for hierarchies.

⁶²⁴ See www.gert-hofstede.com/countries.html.

⁶²⁵ Both long term versus short term Orientation and Indulgence versus restraint have been added as fifth and sixth dimensions but are not included here.

With respect to uncertainty avoidance, Hofstede finds that Nigeria has a higher preference for avoiding uncertainty than the other countries in this analysis, while the UK, Canada and the US are relatively more uncertainty accepting. An uncertainty avoiding society generally has a low risk tolerance, is less entrepreneurial, has a low tolerance of deviant people and ideas, avoids conflict and emphasizes consensus, has a high respect for laws and rules even where those rules do not work, accepts the acts, decisions or opinions of experts and authorities as correct.

The extent to which a society is individualized or collectivized depends on the extent to which its members are in loosely knit relationships where individuals are only responsible for themselves and their immediate family, as in an individualized society, or tightly knit structures where, in return for loyalty, individuals can expect care and support from relatives or other members as in a collectivistic society. It also depends on the extent to which individual or collective achievement is emphasized, the degree of independence exercised in decision making, and the level of recognition accorded to emotional ties to organizations or groups. Its significant determinant is in how self-image is reflected -whether as "I" or "we". On this individualism dimension, Hofstede finds that Nigeria scores significantly lower than other countries and, consequently, is a collectivized society.⁶²⁶

And to the masculinity/femininity dynamic, societies are classified according to their definitions of gender roles. For example, a masculine society is one in which the dominant role is assigned to the male gender, where decisiveness in males is encouraged, where work is given priority, and success and money are emphasized. This is counterposed to a feminine society where cooperation and consensus is encouraged and emphasis is placed on caring for the weak. Hofstede finds that all the countries, including Nigeria, are masculine in nature. Canada is described as moderately masculine because, in some ways, it emphasizes care, emotions and relationships.

⁶²⁶ Nigeria (30), UK (89), Australia (90), US (91), Canada (80) and South Africa (65).

5.1.8.2 Hofstede's Cultural Dimensions: Lessons for Informed Consent and Autonomy in Nigeria

Constructing Nigeria through the lens offered by Hofstede shows that Nigeria is a hierarchical, collectivist and masculine society which, to a significant extent, avoids confrontation and uncertainty. To a larger or smaller extent, the US, UK, Canada, Australia and South Africa are all less tolerant of hierarchy and unequal relationships than Nigeria. They are also more individualistic and, except for South Africa, each of them is uncertainty accepting. Although Hofstede's work looks at how values in the workplace are influenced by culture, his findings are relevant in explaining the peculiar challenges faced in the effort by Nigeria to practice informed consent in the same manner and according to the same values as the other countries. As shown, the prevailing culture in these countries differs significantly from the culture in Nigeria. Given the relativism of culture, an attempt to graft into a cultural setting a practice grown in a different cultural setting assumes cultural universalism.

Even so, it is acknowledged that a concept like autonomy is universal. For example, the movement in Northern Nigeria for greater rights for women, the nuanced interest in maternal health and the reproductive rights of women, the push for girl-child education in Nigeria, the fight against violence against women, the mobilization against traditional widowhood practices, may all be explained on the basis of autonomy, that is, the right to determine what happens to one's body.

However, since Nigeria's socio-economic development is not at a level comparable to those of the western countries, its emphasis on autonomy is also at a foundational level. This means that the agitation is for the recognition of basic rights to education, to be free of harmful and demeaning widowhood practices, to access maternal healthcare, and to exercise reproductive rights. It has not yet advanced to agitation about the modalities of the exercise of the right. In other words, the fight is still about whether the right exists, should exist, and how it is to be brought into existence, instead of how that right should be exercised, whether communally or individually. Framed differently, although the long-run issue is autonomy and the right to bodily integrity, the immediate

challenge for Nigeria is one of access, and overcoming barriers to access, such as illiteracy, poverty, patriarchy. This challenge affects the basic question whether, in the first place, there is a patient whose consent is to be obtained, and second, what the nature of consent may be if it is obtained in any one case.

5.1.9 *Absence of Judicial and Ethical Motivation as a Challenge for Informed Consent*

So far, we have seen that the limitations to the practice of informed consent in Nigeria include trust, religion, a culture of role play, familial influence, demography, and context. Another contextual challenge to informed consent is the general lack of motivation on the part of physicians to comply with informed consent requirements. In Chapter Two, it was argued that informed consent is ethically justified and legally mandated. A failure to obtain informed consent from a patient prior to administering treatment leaves the physician liable to a cause of action in either battery or negligence. A failure to disclose or inadequate disclosure has been a basis for several suits, as in Canada.⁶²⁷ The position is different in Nigeria. Asides from *MDPDT v Okonkwo* and *Esabunor v Faweya* which were based on a constitutional right of freedom of religion, there is no known judicial decision on the right of a patient to give informed consent, and on the duty of physicians to disclose pertinent information to their patients to inform their consent to treatment.

In *MDPDT v Okonkwo*, the Supreme Court indicated the direction courts in Nigeria would likely take in the event that cases that implicate matters of informed consent become more common in Nigeria. As already discussed, the court leaned in favour of autonomy and the right of the adult patient to refuse treatment except where public interest determines otherwise, or where there are children whose interests need to be considered. While this case is helpful, its directional usefulness is limited. It does not, for

⁶²⁷ See *Gallant v Brake-Patten*, [2012] NJ 132; *Lemay v Peters*, [2012] NBJ 59; *Friend v Watters*, [2012] OJ 188.

example, address issues of disclosure and understanding which are necessary for informed consent.

As already highlighted, studies show that the consent of the patient is not sought in some cases before medical treatment. Where it was sought, disclosure was found to be arbitrary. Studies also found that sometimes, patients are not satisfied with the extent of disclosure made. Yet, no case has been made in Nigeria against the physicians involved, either in battery for failing to obtain consent, or in negligence, for failing to disclose the risks of treatment and other material information. One commentator attributes the dearth of cases alleging lack of informed consent to a general sociocultural reluctance to settle medical disputes through litigation.⁶²⁸ According to him, there is a general inclination to settle disputes using elders, religious leaders and family members. It is also attributed to a general inclination to accept medical outcomes as the will of God.⁶²⁹

Beyond the foregoing socio-cultural factors, the paucity of informed consent litigation in Nigeria, and the reluctance to seek legal redress following medical mishap, may be influenced, primarily, by absence of awareness arising from illiteracy and ignorance of the existence of the right to be informed.⁶³⁰ It is also influenced by economic considerations in regard to the cost of litigation and uncertainty of the outcome of the process. Protracted trials and corruption of the Nigerian bar and bench also discourage litigation.⁶³¹ There is optimism that with an increase in literacy, a decline in poverty, and the introduction of a health insurance scheme, more medical malpractice cases will be litigated.⁶³² Certainly, this thesis does not contend that a prevalence of litigation in any society indicates advancement. However, the absence of a judicial authority that upholds the likelihood of liability for non-compliance with the requirements of informed

⁶²⁸ See JA Yakubu, *Medical Law in Nigeria* (Ibadan: Demyax Press, 2004).

⁶²⁹ This point has been extensively discussed under religion as a challenge to informed consent.

⁶³⁰ See Ezeome & Marshall, *supra* note 10.

⁶³¹ *Ibid.*

⁶³² *Ibid.*

consent, arguably, reduces the incentive for physicians to comply with consent procedures.

5.2 Conclusion

Nigeria's practice of informed consent reflects clearly the country's socio-cultural and economic realities. These realities absorb a desirable principle of appropriate relations in healthcare delivery, and have paced conforming practice to their dictates. Consequently, operationalizing informed consent can only become reality with change and improvement in the underlying and conditioning socio-cultural and economic influences.

Among the factors examined as adversely affecting the practice of informed consent in Nigerian healthcare, illiteracy and poverty ranks high. These particular impediments affect whether consent will be sought; what information is disclosed; whether the patient acts autonomously; and whether the patient is able to evaluate the information he or she is given. Primarily, a socially and economically empowered patient may be able to escape the relational influences of patriarchy, gender inequality and role play, on his or her exercise of autonomy. Such patients are more likely to question certain relationships, analyze social expectations and reflect on their choices, and fashion their responses to socializing influences rather than passively accept them. This does not mean that illiterates and poor persons are always unable to exercise full autonomy or that their better positioned counterparts are always able to escape the influences of patriarchy, gender inequality and role play. Rather, it is a matter of the degree or frequency at which full autonomy may be exercised.

As argued in this chapter, both poverty and illiteracy affect the ability of a patient to compel respect of his or her right to self-determination. On the other hand, a literate and economically empowered patient makes a physician to be conscious of liability for failing to obtain proper informed consent. Consequently, if illiteracy and poverty can be eradicated through economic and educational empowerment, and through a hermeneutic engagement with the patient, the effects of patriarchy, religious and other

beliefs will be reduced, and a more nuanced consent practice may develop. Possibly, with education, patients may be aware of their right of autonomy and ensure that it is respected; and with economic power, patients are given the means to protect that right, whether by being able to make a claim in court, or, by paying for the treatment they want.

Chapter Six

Conclusion

Bioethical literature identifies duress, coercion, undue influence and misrepresentation as vitiating consent, since they constrain an individual's autonomous capacity. The influence of oppression on a patient's choice is often overlooked.

Often, oppression may manifest through coercion or undue influence, however, it may be subtle enough to go unnoticed. This thesis views oppression as certain influences which impede full exercise of autonomy by an individual. The thesis finds that such oppression may arise from socialization. Ready examples are patriarchy and religion. Oppression may arise from the arbitrary disclosure practice by physicians by which the nature of information that is disclosed is based on the literacy level of the patient. Oppression may also arise as a result of legislative enactment, such as criminalizing abortion, which limits the options available to an individual in exercising her reproductive autonomy.

The influence of patriarchy is particularly visible in relationships between a husband and wife in Nigeria, especially as it relates to decision making about the wife's reproductive health. It is either that the husband decides the nature of treatment the wife receives, or the pressure to conform to the societal norm which places premium on motherhood and the male gender, forces her to make certain choices.

To a large extent, a Nigerian woman is primarily valued for her reproductive capacity. Her ability to fulfill her biological child bearing role secures, not only for herself, but also her dependents, social security. Particularly, her ability to produce a child of a preferred gender, usually a male child, secures for her a place in her matrimonial home and in the society. This puts her in a position where she may accept any medical option that will enable her, first, to conceive, and, second, to have a male child. The search for a male

child may also cause her to have more children than she wants, and sometimes at the expense of her health.

Through striving by every means available to get pregnant or have a male child, each woman contributes to normalizing societal expectation that a real woman is one who has given birth to a child at all, and particularly a male child. Yet the consequences of not complying with this socially assigned role may be the risk of losing her coveted position as a married woman, or being outranked by a younger and more compliant co-wife.

The possibility of such disruption or demotion is understandably worrisome in a society where women generally derive their identity from that of the men in their lives. This puts women in Nigeria in a double bind where they are disadvantaged whichever way they turn. It is argued that oppressed people fail to act fully autonomously because “the options that are meaningfully available to them do not include a choice that is compatible with their deepest values and needs or because the rewards and punishments for choosing an action that reinforces oppression outweighs the personal benefits of choosing one that would help undermine the oppression.”⁶³³

Also limiting her options is the illegality of abortion in Nigeria except to save the life and health of the woman. By this illegality, the State forces women to have children even where they are not ready. Attempts to surmount this legal hurdle result in accessing unsafe abortion services and contribute to the alarming rate of maternal mortality in Nigeria. Further, because relationships in Nigeria are communal and hierarchical in structure, emphasis is placed on assigned roles and individuals are expected to carry out the roles expected of them. All the foregoing affects the extent to which an individual’s medical decision is voluntary and reflective of his or her values and interests.

Consequently, in analyzing the relational impediments to full exercise of autonomy by patients in Nigeria, it was increasingly clear that, contrary to Western bioethics

⁶³³ Sherwin, *supra* note 502 at 19.

literature in which the debate appears to be about whether patient autonomy prevails or whether paternalism is justified, with a common ground being the patient's best interest, the situation in Nigeria is more complex.

Notwithstanding that the Supreme Court of Nigeria in *MDPDT v Okonkwo* strongly endorsed patient autonomy over the beneficence of the medical profession, and notwithstanding that informed consent and patients' right of self-determination enjoy constitutional protection, informed consent debate in Nigeria is not entirely about either patient autonomy or physician paternalism. Rather, it involves several other interests such as the interest of a husband, the church, the community, and the state, in the medical decisions of a patient. It also involves a social value of obedience, which may warrant complying with medical decisions made by other persons, or with the role expected of a patient, or faithful adherence to a religious doctrine.

In analyzing the shortcomings of the *Code of Medical Ethics in Nigeria*, it was categorically suggested that: competence be assessed functionally; the patient may be cajoled, entreated or persuaded by family members provided he or she is not overwhelmed by the persuasion to the extent that the decision made does not reflect his or her preferences and interests; and, adequacy and materiality of disclosure should be measured by the patient's needs. It was also suggested that both the physician and the patient have a role to play in the medical decision making, the fact of which makes the process leading to the decision collaborative, but the final decision is ultimately for the patient to make.

Ideally, these suggestions should make informed consent more nuanced in Nigerian health care. But, the challenge of obtaining a truly voluntary consent, and how to recognize such consent, is particularly problematic given the various relational factors that might impede a voluntary exercise of autonomy. A patient might be declared functionally competent to decide his or her medical treatment. He or she may receive adequate information to enable him or her make an informed decision. Yet, if the patient is not allowed to make the decision that she wants, either because, for a female

patient, her husband's consent, not her own, is required, or because the patient feels compelled, owing to his or her socialization, to make a particular choice, or because the physician withheld or manipulated necessary information, then the essence of informed consent will be defeated.

Thus, this thesis finds that autonomy of a patient in Nigeria cannot be fostered or enhanced merely by assessing competence functionally, or by providing extensive information or by scheduling several counseling sessions in order to allow the patient to make a reasoned and unhurried decision. The social circumstances from which the patient must make his or her decision must be conducive to such decision making. Such decisions must also reflect the patient's own values. It is a truism that for every value that is formed or any action that is taken, there are antecedent causes that shape those values and those actions. As such, it is impossible to escape one's social environment. But, as Linda Barclay observes, the difference between an autonomous person and a nonautonomous person is that "the autonomous person is not a passive receptacle of [the societal influences] but reflectively engages with them to participate in shaping a life for herself."⁶³⁴

Consequently, to promote autonomy transcends focusing on the patient and arming him or her with extensive information to be able to cope with decision making. It requires overhauling the socio-cultural background of Nigeria from which decisions are made.

The foregoing analysis is made possible through the relational theoretical frame work that is adopted. As mentioned at the beginning of this thesis, a relational theory enables analysis of how oppressive socialization and oppressive social relationships impede autonomous agency at three levels: (i) at the time of formation of an individual's

⁶³⁴ Linda Barclay, "Autonomy and the Social Self" in Catriona Mackenzie & Natalie Stoljar, eds, *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self* (New York: Oxford University Press, 2000) 52 at 55.

desires; (ii) at the time of developing the ability to be autonomous; and (iii) at the time of exercising autonomy or making autonomous choices.

Using this framework, it was found, at the first level that the socializing effect of paternalism, religion, and stereotypical role play, contribute in shaping an individual's values, beliefs, and desires. At the second level, it was found that developing the capacities for self-reflection and self-direction requires empowerment of the individual and eliminating the impediments to his or her autonomous capacity. It was found that the exercise of autonomy may be overtly impeded at the third level by legislation, such as the *Criminal Code* which makes it illegal to access abortion services unless the life and health of the woman are in danger. It also found that autonomy can be impeded by norms and social expectations which effectively reduce the range of significant options that are available to patients.

As earlier mentioned, it may not always be possible to enhance the autonomy of a patient through extensive information disclosure or through insisting on an uncoerced choice from a variety of options. According to Susan Sherwin, an individual may not improve his or her degree of autonomy simply by improving his or her understanding of the nature of decision that he or she is to make, he or she also has to be properly situated in favourable circumstances.⁶³⁵ Accordingly, enhancing autonomy may require more than educating the individual on the risks and alternatives to treatment, or requiring a more thorough informed consent standard. Based on a relational view, a clarion call may be made on the State, the medical profession, and other individuals to ensure that the patient has full autonomy, and that there is no coercion on his or her exercise of autonomy.

On the part of the State, it may require the development and adoption of policies which would, for example, overturn the legislative impediment to women deciding on whether or not to carry a pregnancy to term. It may also involve the adoption of policies that will

⁶³⁵ Sherwin, *supra* note 502 at 19.

deliver sustained economic and educational power to the citizens – actual and potential patients.

For the medical profession, it may require actively engaging with the patient in more meaningful ways that will ensure that the patient's personal values are reflected in the medical decision that he or she makes. It also requires deliberately seeking consent from a female patient, rather than her husband, where the patient is capable of understanding and appreciating the implication of her decision. Overall, it requires deep commitment to the ideal of autonomy irrespective of the social or economic class of the patient.

At the community level, enhancing patient autonomy by removing the impediments to it may necessitate a change of mindset, both in the general expectations from the patient, and in the attitude of members of the community towards his or her increasing assertions of autonomy.

Patients also have a role to play in enhancing their autonomous capacity. For example, they may consciously and deliberately repudiate the oppressive socialization, thoughts and beliefs that they have internalized.⁶³⁶ However, without the support and cooperation of the State, physicians, and other members of the community, such repudiation may potentially exacerbate the oppression and severe long established social ties.

Overall, it may be concluded that informed consent will work in Nigerian healthcare if there is a firm commitment to patient autonomy, particularly by the key players in the society. This demands the adoption of a different mindset and a more genuine tolerance

⁶³⁶ See Diana Tietjens Meyers, "Intersectional Identity and the Authentic Self?: Opposites Attract!" in Catriona Mackenzie & Natalie Stoljar, eds, *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self* (Oxford: Oxford University Press, 2000) 151 at 170. Meyers suggests that a better attitude may be ambivalence towards one's oppression which, according to her, is more likely to preserve one's autonomy and balance.

of autonomy. Changing mindsets is potentially difficult, more so when what is involved is a long established practice. Yet it is necessary for this change to be brought about in order for patients – actual and potential – to be able to exercise full autonomy in decisions concerning their health, and so, to enjoy the fullness of their bodily integrity and self-determination.

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