



Research Paper

## The Right to Patients' Informed Consent in Nigeria and South Africa: A Comparative Discourse

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### ABSTRACT

Every human has the universal, inalienable right to self-determination, self-preservation, human dignity and autonomy. This right when expanded includes the right to know and decide what happens to his or her body including the appropriate medical treatment or procedure meted out during the pendency of an ailment. Consequently therefore, this seminar paper seeks to contextualise and comparatively analyse patients' informed consent which includes the autonomous authorisation by patients of their elective medical intervention in Nigeria and South Africa. This paper found that whilst it is standard practice that medical treatment should not proceed unless the doctor or other medical practitioner has first obtained the patient's consent which may either be express or implied, but this is often not strictly adhered to for a number of reasons and that part of the major challenges militating against the proper practice of informed consent in Nigeria include medical paternalism (the 'my doctor knows best' syndrome), lack of education of patients, language barriers, insufficient administrative support, most especially patient interpreters and Geriatric doctors to attend to aged patients, large patient numbers, excessive workload and time constraints within which to ask the requisite consent questions, but many of these challenges equally affect the South African health sector with its better developed healthcare system, but only in a lesser proportion. The paper concludes by making a few recommendations that can better improve the culture of seeking the consent of patients before the administration of medical treatment in the selected jurisdictions.

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### I. INTRODUCTION

The patient's right to validly give consent in his/her conscious state to any medical treatment proposed by medical personnel has recently gained international recognition.<sup>1</sup> The principle of the inviolable right of the individual to choose and to decide the circumstances of his health is the fulcrum upon which this right to consent to medical treatment is predicated.<sup>2</sup> The consent must be voluntarily given by a patient who possesses the requisite legal capacity to give such consent. There must equally be full disclosure of information relating to treatment, benefit, risk involved, the complication and consequences of such procedure. The physician is thus under the obligation to provide all the necessary information regarding a procedure or treatment to be carried out on the patient. In Nigeria, medical and legal researchers have noted that the issue of free, prior, informed consent in medical practice is poorly implemented, but the same cannot be said of South Africa with a better developed mechanism for obtaining patient-informed consent prior to any medical procedure. It has also been argued that Nigeria's law on informed consent is grossly inadequate<sup>3</sup>. Several factors have been noted to be responsible for this<sup>4</sup>. These problems range from low level of literacy in Nigeria, poor healthcare delivery system, ineffective prosecutorial powers for medical infractions to lack of viable right enforcement mechanisms<sup>5</sup>. Illiterate patients tend to rely completely on the judgment of the physician and trusting them with

<sup>1</sup> S.D Pattison, *Medical Law and Ethics* (Sweets & Maxwell 2006) 97.

<sup>2</sup> J. Cutan, 'Informed Consent: An Ethical Obligation or Legal Compulsion' (2008) 1 (1) *Journal of Cutaneous and Aesthetic Surgery* 33 at 35.

<sup>3</sup> F.O Emiri, 'Medical Law and Ethics in Nigeria' (Malt house Press Limited. Lagos 2006) P. 71.

<sup>4</sup> Ibid.

<sup>5</sup> Ibid.

their lives with a reckless abandon and lack of caution or precaution. The fact that the right to informed consent is poorly enforced also renders the challenge more ominous. This is more complicated by the fact that there is limited remedy available under the Nigerian legal system to patients whose rights to informed consent have been unilaterally violated.

Patient-informed consent is largely deemed an ethical doctrine. The UNESCO International Bioethics Committee (IBC) report on consent argues that, 'autonomy implies responsibility'. That the power to decide for one's self entails *ipso facto* acceptance of the consequences of one's actions, which can have far reaching consequences especially in matters of health<sup>6</sup>. Therefore, a person needs to be informed of the precise consequences of his/her choice, and this in turn leads one to consider the conditions under which consent is obtained. Respect for the autonomy of persons making decisions, while taking responsibility for those decisions, is closely aligned to Article 1 of the Universal Declaration of Human Rights (UDHR) which holds that all human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood. In view of the foregoing, it could be argued that the doctrine of informed consent has evolved into a rule of law that requires that no diagnostic or therapeutic procedure should be performed on a patient, without full disclosure of the risks of the procedure and any alternatives to it, prior to giving consent.

Furthermore, the mechanisms for enforcing the right to informed consent are continually hampered by bureaucratic bottlenecks and judicial delays predicated on lack of sufficient authority and forensic evidence in medico-legal jurisprudence. This seminar paper thus seeks to make a comparative analysis between the right to patient-informed consent in Nigeria and South Africa with a view to making the Nigerian medico-legal system learn from the South African experience and legal development in medical Jurisprudence.

### **1.1 Research Questions**

This Seminar Paper seeks to answer the following questions:

1. What is referred to as Patient-informed consent in Nigeria and South Africa?
2. Do patients lose their rights to consent so far the medical personnel is competent and believes the treatment and medical procedure is the best for the patient in the circumstance notwithstanding not obtaining the consent?
3. What is the regulatory framework and reforms that can be introduced to stimulate, encourage and sustain patient-informed consent in Nigeria from South Africa?
4. What is the legal and regulatory framework for the regulation, administration and sustained facilitation of patient-informed consent in Nigeria and South Africa?

### **1.2 Aim and Objectives**

1. To study and appraise the concepts and content of patient-informed consent in Nigeria and South Africa.
2. To appraise the challenges confronting the operability of patient-informed consent in Nigeria.
3. To assess the degree of adherence to patient-informed consent and evaluate the quantum effect of patient-informed consent on Nigeria's healthcare delivery.
4. To identify the incentives and the legal framework sustaining patient-informed consent in South Africa with a view to recommending same to the Nigerian legal system.

### **1.3 Research Methodology**

The methodology adopted in this study is analytical, expository and library-based. Data collection shall be from contemporary Law and Medicine journals online and in the library and from seasoned medical practitioners, patients, medical record officers, the courts and consultants in Nigeria and South Africa.

### **1.4 Significance of the Topic**

Without a sustainable and worthwhile patient-informed consent template in Nigeria, some medical personnel can take undue advantage of the situation to harm their patients without validly obtaining their consent. In medical practice, since there is a fundamental principle that every individual has a right to decide or determine what happens to his/her body and the law owes an obligation to protect such rights, thus, this seminar would assist patients in protecting such rights. It would equally ensure that every person gives express consent before any procedure is carried out on that person, and that such individual has an unfettered right to accept or refuse treatment. However, the exception is in emergency situation and or overwhelming interest of the public.

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<sup>6</sup> International Bioethics Committee (IBC): Report of the International Bioethics Committee of UNESCO on Consent. Social and Human Sciences Sector, Division of Ethics of Science and Technology, Bioethics Section SHS/EST/CIB08-09/2008/1, UNESCO 2008.

It is observed that in medical practice in Nigeria, consent to treatment is grossly inadequate because necessary information is withheld from patients, some necessary information or details are taken for granted. The reason adduced for this lapse is the poor educational status of many patients in Nigeria. There is also the issue of the confidence placed on the physician by the patient which results in heavy reliance on the decision of the physician. Other factors adversely affecting consent in medical practice in Nigeria include: poverty, undue influence of family, lack of professionalism, over-familiarity, overzealousness and religious belief. All these issues would be better addressed and resolved in the light of this study that seeks to learn from the South African experience.

It is noted that just as the Supreme Court of Nigeria emphasized the importance of consent in the case of *Medical and Dental Practitioner Disciplinary Tribunal v Okonkwo*,<sup>7</sup> when it stated that patient's consent is paramount in a doctor/patient relationship and the choice of a competent adult with a sound mind should be respected. It is of fundamental importance that the physician must give a detailed explanation of the procedure as a patient has the right to know what procedure he intends to go through. All material facts ought to be explained, the risks and the costs too.

This study is therefore important to bring out the issues to the fore with a view to addressing them. This seminar is also essential in assisting the Nigerian legal and medical space seek for viable solutions from South Africa to the lack of sufficient patient-informed consent in the country by having a robust regulatory framework and incentivisation. A consideration of the regulatory tools identified in this research proposal will certainly help to reposition the healthcare sector of Nigeria. This paper will finally seek to fill two gaps: first, it would contribute to the discussion on the importance of ensuring the giving of patient-informed consent in Nigeria. Furthermore, it will critically examine the importance of giving valid patient-informed consent the two selected jurisdictions. Secondly, the seminar will provide a more in-depth and critical review, particularly in light of the situation and legal jurisdiction in South Africa. It is however noted that one of the reasons for choosing South Africa as a comparative benchmark is the striking similarity between the legal systems and the healthcare industry's structure and the fact that the legal and healthcare system of South Africa is more advanced.

### **1.5 Contextualizing Patient-Informed Consent**

At the global plane, the recognition of the patient's right to consent to any medical treatment proposed by medical personnel is very significant in the medical profession. It is a valid precursor to the right and locus of the medical personnel to validly administer treatment on the patient. The contention would however arise on whether or not showing up at a hospital is not sufficient proof that a patient presumably consents in trust to any kind of medical treatment to be administered by the medical personnel attending to him or her, so far he or she presents himself or herself of their own volition to the doctor, whether or not the pros, cons and possible negative outcomes of such medical procedure is first explained the language the patient understands. The principle of the right of the individual to choose and to decide the circumstances of his health therefore necessitates this consent.<sup>8</sup> Mills for instance contended that an adult individual who is of sound mind has an absolute right over his or her mind and body. The consent must be free, prior and informed. The term 'Prior' equally implies that such consent must be sought sufficiently in advance of any authorization by the medical or hospital authorities or commencement of activities by a hospital that affects the health of the patient and not obtained after the administration of the treatment or by presumption<sup>9</sup>. To be duly and fully informed means that the patient's consent must only be sought after full and legally accurate disclosure of the full information concerning the proposed medical procedure has been made to the patient. The disclosure must therefore be made in a form which is both accessible and understandable by the patient regarding inter alia the nature, scope, duration, potential risks and foreseeable implications of the medical procedure.

Informed consent is therefore contextualized as 'a person's agreement with a recommended medical procedure with full knowledge of the risk involved and the alternatives thereof before such consensual agreement'.<sup>10</sup> It is therefore noted that it is the patient's consent that gives the mandate for any form of treatment or medical procedure to be administered on him by the attendant medical personnel<sup>11</sup>. The consent required in medical cases is of very high standard. This is similar to the consent that is required by the international human rights instruments on indigenous rights which pre-supposes the existence of a set of group rights belonging to specific people that are considered 'original inhabitants' or 'aboriginal' to the territory on which a State is located in contrast to other citizens of their States who are considered foreign settlers on the territory.

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<sup>7</sup>(2001) 7 NWLR (Part 711) 206.

<sup>8</sup>*Ibid.*

<sup>9</sup>J.A Dada 'Legal Aspect of Medical Practice in Nigeria'. (Princeton Publishers, Lagos 2016) P. 23.

<sup>10</sup> Black's Law Dictionary' (8th Edn. St Paul M.N USA) 323.

<sup>11</sup> F.O Emiri, 'Medical Law and Ethics in Nigeria' (Malt house Press Limited. Lagos 2006) P. 71.

Patient-Informed consent has been adduced to be free, prior and informed.<sup>12</sup> Free implies that consent is not valid if obtained by manipulation or coercion. Where consent is obtained involuntarily, by duress or coercion, it may result in an action for battery.<sup>13</sup> The consent must be voluntarily given by a patient who has the legal capacity to give such consent.<sup>14</sup> Prior implies that consent must be sought sufficiently in advance of any authorization by the medical or hospital authorities or commencement of activities by a hospital that affects the health of the patient. Informed means that the patient's consent must only be sought after full and legally accurate disclosure of information concerning the proposed medical procedure has been given to the patient. The disclosure must be in a form which is both accessible and understandable by the patient regarding inter alia the nature, scope, duration, potential risks and foreseeable implications of the medical procedure. There must be full disclosure of information relating to treatment, benefit, risk involved, the complication and consequences of such procedure. The physician provides all the necessary information regarding a procedure or treatment to be carried out on the patient.<sup>15</sup>

In Nigeria, it is noted that the issue of free, prior, informed consent in medical practice is faced by poor implementation. Several factors have been adduced to be responsible for this. There is the problem of low level of literacy in Nigeria as illiterate patients tend to rely completely on the judgment of the physician<sup>16</sup>. The fact that the right to informed consent is poorly enforced is another challenge. There is limited remedy available in Nigerian law to patients whose rights to informed consent have been violated coupled with the fact that the mechanisms for enforcing the right to informed consent are hampered by needless bureaucracies<sup>17</sup>.

Informed consent is a basic requirement in the patient–physician relationship. While its origin and development lie in Western European culture,<sup>18</sup> its principles have been found to be compatible with an analysis of basic human behaviour and therefore applicable in all cultures.<sup>19</sup> These principles represent core human rights that we would wish to see honoured universally, despite local variations in their superficial aspects.<sup>20</sup>

## II. PATIENT-INFORMED CONSENT IN NIGERIA

The regulation of informed consent in Nigeria does not seem to be altered by any unique attribute of the local culture or social context. This is not surprising in view of the country's colonial heritage and the multicultural and the pluralistic nature of the Nigerian society. The professional conduct of medical doctors is guided by the *Code of Medical Ethics in Nigeria*, in which Rule 19 of part A deals with informed consent.<sup>21</sup> Its stipulations and the notion of autonomy and human rights espoused resemble that of any developed Western country. This Code of Medical Ethics in Nigeria is equally the prime regulatory framework introduced to stimulate, encourage and sustain patient-informed consent in Nigeria. It recognizes that consent can be obtained from the patient, his/her relations, or the public authority, depending on the situation. While the Nigerian patient holds the primary right to information and any decision about his or her treatment, a next of kin can give consent for minors and those without capacity<sup>22</sup>. When no relative is available, the most senior doctor in the institution can give an appropriate directive to preserve life. A court order may be needed in special circumstances<sup>23</sup>.

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<sup>12</sup> L. B Fontana, J Grugel, 'The Politics of Indigenous Participation through "Free, Prior, Informed Consent": Reflections from the Bolivian Case,' (2016) 77 *World Development* 249 at 250.

<sup>13</sup> Battery is referred to in Law as the unjustifiable application of unlawful force or contact to the person of another. J G M Tyas, *Law of Torts* (Macdonald and Evans 1973) 36.

<sup>14</sup> Pattison, *supra*.

<sup>15</sup> D. Goguen 'What is 'Informed Consent' in Medical Malpractice Case'. Accessed 25<sup>th</sup> July, 2021; J.A Dada 'Legal Aspect of Medical Practice in Nigeria' (University of Calabar Press, Nigeria 2006)p 257- 218.

<sup>16</sup> *Ibid*.

<sup>17</sup> *Ibid*.

<sup>18</sup> J.W. Berg et al., eds. 2001. *Informed Consent: Legal Theory and Clinical Practice*. New York, NY: Oxford University Press.

<sup>19</sup> National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research. 1979. *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research*. Washington, DC: US Government Printing Office. Available at: <<http://ohsr.od.nih.gov/guidelines/belmont.html>> Accessed 4th August, 2021.

<sup>20</sup> Levine, R.J.. Informed Consent: Some Challenges to the Universal Validity of Western Model. *Law Med Health Care* 1991; 19: 107–213.

<sup>21</sup> Medical and Dental Council of Nigeria. 2004. *Codes of Medical Ethics in Nigeria*. Surulere: Petruvanni Co. Ltd: 26–31.

<sup>22</sup> *Ibid*.

<sup>23</sup> *Ibid*.



Consent discussions and forms should be witnessed. The code<sup>24</sup> specifies that a proper informed consent must include (1) the benefits and risks of a procedure, (2) appropriate professional advice on options, (3) the patient's choice of preferred option, and (4) authorization for the clinician to commence treatment by completing the form<sup>25</sup>. The code recognizes the inherent right of a patient to his/her body and life. While acknowledging different types of consent (including voluntary self-offer for treatment), the code insists that certain interactions deserve expressly defined and documented consent. It provides a standard consent form and does not recognize any other form used by individual physicians.<sup>26</sup>

It is instructive to note that consequent on the fact that the Nigerian legal system is based on British law, most procedural cases are derived from that legal system. Medical practice in Nigeria is relatively free of malpractice litigation compared to developed countries. Accusations of medical negligence, incompetence and unethical or unprofessional conducts are common, but most of these cases are adjudicated by the disciplinary committee of the Medical and Dental Council of Nigeria: the body that regulates professional medical practice in Nigeria. The decision of the disciplinary committee can be appealed in the regular Appeal Courts, but such cases are the exception.<sup>27</sup>

Current legal, moral, medical and philosophical thought lists five elements for a valid informed consent, comprising: two preconditions – voluntarism and capacity; two information elements – disclosure and understanding; and a decision element – consenting or refusing.<sup>28</sup> Within the Nigerian context, local, social and cultural factors have an effect on how these are applied in the patient-physician relationship. Empirical studies in the country have shown that Nigerians appreciate what it means to act voluntarily.<sup>29</sup> However, several local factors may impede the actualization of this, including the huge authority figure of the physician and pressures from family relations, as well as religious obligations.<sup>30</sup> The physician is such an authority figure in medical matters that patients feel obligated to follow whatever the doctor tells them. Medical paternalism is the norm in Nigeria and patients expect it from their physicians<sup>31</sup>. Some patients actually see the fact that the doctor asked them to make a choice as a sign of incompetence. Paternalism is, however, not a unique cultural phenomenon, and has occurred at one time or another in the history of all modern societies. It is a hallmark of traditional societies with high levels of illiteracy and ignorance. Physicians striving to practice informed consent in this setting must therefore spend a lot of time on patient education and consciously and tactfully bring the patient into the decision making process of the relationship.

Consequently, Nigerian physicians believe that their patients generally do not like inconsiderate 'cold shower' approaches to risk disclosure.<sup>32</sup> Many of the risk disclosures carried out in the US settings would be viewed negatively by Nigerian patients.<sup>33</sup> This is the word of Dr. Simon Olawole in a focus group discussion of Nigerian physicians involved in informed consent for genetic studies<sup>34</sup>:

*In the Unites States, we say things like "You may die ... this may not benefit you." I had a resident who was keen on informed consent. She would tell patients that they could die. [She would tell them this] pre-op [before they went into surgery] ... and they would say, "why are you telling me I could die?" they [the patients] thoroughly abused her. We [Nigerians] don't like to talk about it. It makes it more important ... it distorts the importance [of the risk of dying]<sup>35</sup>.*

<sup>24</sup> *Ibid.*

<sup>25</sup> *Ibid.*

<sup>26</sup> Ezeome, Emmanuel & Marshall, Patricia. (2008) Informed Consent Practices in Nigeria. *Developing World Bioethics*. 9. 138-48.10.1111/j.1471.2008.00234.x.

<sup>27</sup> *Ibid.*

<sup>28</sup> T.L. Beauchamp & J.F. Childress, eds. 2001. *Principles of Biomedical Ethics*. 5<sup>th</sup> rev edn. New York, NY: Oxford University Press.

<sup>29</sup> Marshall, P.A. et al. Voluntary Participation and Informed Consent to International Genetic Research. *Am J Public Health* 2006; 96: 1989– 1995.

<sup>30</sup> P.A. Marshall. 2001. Relevance of Culture for Informed Consent in U.S.-Funded International Health Research. In *Ethical and Policy Issues in International Research: Clinical Trials in Developing Countries*. Vol. II. Bethesda, MD: National Bioethics Advisory Commission: C1–C38.

<sup>31</sup> *Ibid.*

<sup>32</sup> *Ibid.*

<sup>33</sup> Marshall, *supra*.

<sup>34</sup> National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. 1979. *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research*. Washington, DC: US Government Printing Office. Available at: <<http://ohsr.od.nih.gov/guidelines/belmont.html>> Accessed 4th August, 2021.

<sup>35</sup> *Ibid.*

Physicians involved in informed consent studies in Nigeria have therefore stressed the need not to take the possibilities of risks out of context for the patients. Risk disclosure has to be realistic but not 'make a mountain out of mole hill'.<sup>36</sup> Empirical evidence, however, shows that Nigerian patients (like most of their counterparts in more developed countries) are not satisfied with the level of information they receive from their doctors. The less educated the patient, the less information physicians disclose to them and the more dissatisfied they are with the information disclosed.<sup>37</sup> It is on this note that no local study has looked at the level of risk information that Nigerian patients would like to receive. A sensitive issue, however, is any procedure involving blood withdrawal, loss or spillage.<sup>38</sup> Because of the vitality ascribed to blood as well as the spiritual and relational interpretation of blood in Africa, any amount of blood is significant and a detailed explanation of its use and the safety of the patient will be necessary and is often demanded.

Life in many parts of Nigeria is still communal and the basic unit of existence is not the nuclear family, but the extended family.<sup>39</sup> While Nigerians value family relationships and use them much more than the Western world in making decisions, they have a good sense of autonomy and individual's right to decision making in the medical context. Consent may therefore be given by patients only after consultation with their husbands, elders and significant others in the family; in some instances family members give proxy consents for patients.

It is noted that Patient-Informed Consent is important for many reasons. The Supreme Court of Nigeria recognised the importance of consent in the case of *Medical and Dental Practitioner Disciplinary Tribunal v Okonkwo*,<sup>40</sup> thus: The patient's consent is paramount...the patient's relationship with a doctor is based on consensus,... the choice of an adult patient with a sound mind to refuse informed consent to medical treatment, barring state intervention through judicial process, leaves the practitioner helpless to impose a treatment on the patient.

Beyond the Okonkwo case, the courts in Nigeria have not defined the limits of the duty of consent on the physician and, thus, not much information is disclosed to the patients in actual practice. While local culture and social demands may influence the actual practice of informed consent in Nigeria, the above legal ruling, like the regulations, addressed informed consent like any Western system. Analyses of medical laws in Nigeria by legal scholars also mirror closely the demands of the law in the United States (US) and Britain and cite them as precedents.<sup>41</sup> What is not easily discernible, however, is the limits the courts will impose on medical practitioners in actual adversarial proceedings. While the Okonkwo case made news within the Nigerian medical community because it was the first of its kind, its full impact on informed consent among physicians was not realized because it was perceived by many of them as a case of the right of Jehovah's Witnesses to refuse blood transfusion. This ruling, however, threw more light on the expectations in the patient-physician relationship in Nigeria and points to the likely course legal rulings will take if and when litigations become a major part of the significant forces shaping consent practices in Nigeria.<sup>42</sup> The recognition of a patient's right to give consent is not unique to Nigeria. The English Common Law recognized the right of every person to bodily integrity and its protection against invasion by others.<sup>43</sup>

Similarly, Caroso J, in the United States case of *Schloendorff v Society of New York Hospital*<sup>44</sup> stated the capacity to give informed consent thus: 'Every human being of adult years and sound mind has a right to determine what should be done to his body...' It is important for a patient/client to be adequately informed about his/her medical condition. Furthermore, there is a distinction between consent obtained for clinical practice and that for medical research. Informed consent for clinical practice involves medical procedures, treatment or surgery while informed consent for medical research is regulated. The Belmont Report and the

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<sup>36</sup> *Ibid.*

<sup>37</sup> O.C Osime, *et al.* Current Practices and Medico-Legal Aspects of Pre-Operative Consent. *East Afr Med J* 2004; 81: 331– 335. See also; Aisuodionoe-Shadrach, O.I., Ogunlade, O.S. & Amoran, O.E.. An Evaluation of the Informed Consent Process for Elective Surgery at a University Hospital. *Niger J Med* 2006; 15: 281– 284.

<sup>38</sup> P.A. Marshall. 2001. Relevance of Culture for Informed Consent in U.S.-Funded International Health Research. In *Ethical and Policy Issues in International Research: Clinical Trials in Developing Countries. Vol. II.* Bethesda, MD: National Bioethics Advisory Commission: C1–C38.

<sup>39</sup> *Ibid.* see also; E. Amadi, ed. 1982. *Ethics in Nigerian Culture.* Ibadan: Heinemann Educational Books Ltd.

<sup>40</sup> (2001) 7 NWLR (Part 711)79.

<sup>41</sup> J.A. Yakubu, ed. 2004. *Medical Law in Nigeria.* Ibadan: Demyax Press. See also, A.J. Dada. 2002. Consent to Medical Treatment. In *Legal Aspects of Medical Practice in Nigeria.* A.J. Dada, ed. Calabar: University of Calabar Press: 157–171: 158. And; Nweze, C.C.. Medical Negligence: Comparative Contemporary Legal Perspectives. *Consumer Journal* 2005; 1: 35– 67.

<sup>42</sup> Ezeome, Emmanuel & Marshall, Patricia. *Op.cit.*

<sup>43</sup> Mason & Mc Call Smith Law and Medical Ethics (7th Edition Butterworth London 2006) 349.

<sup>44</sup> (1914) 105 N.E.

Nuremberg Code equally regulates informed voluntary consent for human subject research. This research must however be explained to the patient involved that the consent obtained is for research and not for therapeutic purposes, so the patient has a right to withdraw at any point in time from such research.<sup>45</sup>

Informed consent is a process of communication between a clinician and a patient, which results in the patient's agreement to undergo a medical procedure. Rule 19 Part A: Code of Medical Ethics of Nigeria<sup>46</sup> and Section 23 of the National Health Act 2004 prescribe the process of obtaining consent before a medical intervention. The equitable law of torts and/or criminal liabilities that deal with medical negligence should be invoked more often by patients whose right to informed consent is denied by medical practitioners.

Practitioners involved in procedures requiring the consent of the patient, his relation or appropriate public authority must also ensure that the appropriate consent is obtained before such procedures, either for surgery or diagnostic purposes, are done, be they invasive or non-invasive. It is further noted that Consent forms should be in printed or in written form either as a part of case notes or in separate sheets with the institution's name boldly indicated. Explanations to patients from whom consent is being sought should be simple, concise and unambiguous about expectations<sup>47</sup>. Proper counselling should also precede the signing of the consent form. In situations where the patient is underage, (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.

Also, in the absence of a next-of-kin, the most senior doctor in the institution can give appropriate directive to preserve life. In special situations, a court order may need to be procured to enable life-saving procedures be carried out<sup>48</sup>. In some cases, which may involve surgical procedures that are difficult to reverse or involving removal of organs e.g. sterilization, amputation of limb, etc, counselling sessions should be undertaken at a minimum of three (3) sittings to give the patient ample time to take an informed decision before a consent form is signed<sup>49</sup>. Time interval for counselling should be at least four (4) weeks if the clinical situation permits. Care should also be taken to ensure that all consent forms are also signed by witnesses. Discussion and explanation to the patient must be in the language in which the patient is fluent and when necessary, through a competent interpreter. The attendant benefits and risks are to be clearly laid before the patient. Appropriate professional advice on options must be given. The preferred option is to be chosen by the patient who will then authorize the clinician by completing the Form MDCN/COMEIN/R19<sup>50</sup>.

It is restated that an essential element of Good Medical Practice is the recognition by the attending physician or dental surgeon, of the inherent right of the patient to his own body and life, Practitioners in the line of duty has the privilege of access to the body and even the corporal depths of the patient. He is also privileged to access the social secrets as might be conferred on him by the patient, his relation or friend. In the process of clinical encounter, the physician or dental surgeon may need to conduct, by physical approach or invasive means certain investigations, procedures or therapeutic manoeuvres on the patient<sup>51</sup>. In such a situation, it is imperative and considered as good practice to obtain some form of formal consent from the patient. This professional manner of relationship universally distinguishes situations of good practice from what may otherwise amount to an assault on the patient. This further enhances the protection of fundamental Rights of the patient. Events that are unfolding, as the Investigating Panel looks into several cases, show that many practitioners are oblivious of what a proper consent should be. The Code of Medical Ethics in Nigeria which recently succeeded the Rules of Professional Conduct for Medical and Dental practitioners in Nigeria recognizes some forms of consent which are imperative to be obtained by a practitioner from the patient. Although, the voluntary self-offer for professional care by the patient to the practitioner is an expression of consent coming from the patient, the profession insists that certain interactions deserve specific and expressly defined and documented forms of consent<sup>52</sup>. It is also noted that the Medical and Dental Council of Nigeria is aware that there is no standard format for obtaining consent for procedures and surgical interventions on patients in Nigeria and as of now, there are indeed practitioners who do not insist on formal consent to intervene on the body of the patient, for adequate ethical protection<sup>53</sup>. Whilst some consent may be concluded verbally, it is based on the necessity to correct this unwholesome situation that the Medical Council has approved a simple format for guidance and use in clinical management. The approved format, coded Form MDCN/COMEIN/R19 is included

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<sup>45</sup>Informed Consent in Human Subject Research (Office for the Protection of Research Subject) Available @<http://oprs.usc.edu/education/booklets>. Accessed 11th July, 2021.

<sup>46</sup> Code of Medical Ethics in Nigeria.

<sup>47</sup> *Ibid.*

<sup>48</sup> Mason, *supra*.

<sup>49</sup> Yakubu, *supra*.

<sup>50</sup> *Ibid.*

<sup>51</sup> Osime, *supra*.

<sup>52</sup> Dada, *supra*.

<sup>53</sup> Emiri, *supra*.

here as a part of Rule 19 of the Code of Medical Ethics in Nigeria for the purpose of universal application throughout Nigeria, whether or not this consent form is regularly administered prior to every treatment remains to be seen. This form is now the standard layout to be used by the registered practitioners in Nigeria to obtain appropriate consent to carry out procedures on patients. All other formats for obtaining consent for procedures on patients are hereby by this regulation declared invalid and ineffectual<sup>54</sup>.

### III. PATIENT-INFORMED CONSENT IN SOUTH AFRICA

It has long been part of South African law that a patient must provide informed consent for all medical treatment, both diagnostic and therapeutic on him or her. This was the position in *Stoffberg v Elliot*.<sup>55</sup> Patient-informed consent simply means that sufficient information is provided to the patient to make an informed decision and that the patient actually understands the information and the implications of acting on that information. Informed consent is concerned with the person's right to human dignity and autonomy. In a similar vein, the medical practitioner has the duty to obtain the consent as he or she is in a position to answer questions and provide further details.<sup>56</sup> The regulatory framework introduced to stimulate, encourage and sustain patient-informed consent in South Africa is the Health Practitioners' Council of South Africa Guidelines. Booklet 9 of the Health Practitioners Council of South African Guidelines further provides that healthcare practitioners should give their patients the information they ask for or need about their condition, its treatment and prognosis; give information to their patients in the way, manner and language they best understand, taking into account the patient's literacy level, understanding, values and belief systems; refrain from withholding from their patients any information, investigation, treatment or medical procedure the healthcare practitioner knows would be in the patient's best interest; apply the principle of informed consent as an ongoing process and allow patients full, unrestricted access to their medical records.<sup>57</sup>

The National Patient's Rights Charter 1998<sup>58</sup> equally provided that everyone has a right to be given full and accurate information about the nature of one's illnesses, diagnostic procedures, the proposed treatment; the costs involved and the possible risks associated therewith. The elements of patient-informed consent includes that it must be voluntary and without constraint; written or implied especially for HIV tests; it must not conflict with good morals or the constitution; capable of giving consent, (either personally or by proxy); the patient should understand why the medical practitioner needs the results of the test; there should be sufficient information on the diagnosis, proposed treatment, expected benefits, risks, alternative treatment, probable results, etc and the patient must actually understand everything or at least arrangements must be made to assist the process of understanding.

According to the HPCSA Guidelines for Good Practice in the Health care professions, there are general and ethical guidelines which must be adhered to for a practitioner to be practicing within the ethical and legal boundaries which is required not only by law, but also by moral code.<sup>59</sup>

The following are elements of informed consent:

- Consent must be voluntary and without constraint;
- In the case of a HIV test, consent should preferably be written, although consent may be implied;
- Consent must not conflict with good morals or the Constitution;
- The patient must be capable of consenting;
- The patient must give the consent personally, unless proxy consent is applicable;
- The patient should know why the medical practitioner needs the results of the test;
- There should be sufficient information on the diagnosis, proposed treatment, expected benefits, risks, alternative treatment, probable results, etc;
- The patient must actually understand, i.e. there is likely to be a need for an interpreter or at least sensitivity that the patient may not actually understand everything and arrangements should be made so as to assist the process of understanding.

In a number of cases, a patient may not be able or capable of giving informed consent. In terms of the Child Care Act, a child that is older than 14 years may independently consent to medical treatment. This means that such a child can consent to a HIV test without his/her parents/guardian knowing<sup>60</sup>.

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<sup>54</sup> Osime, *supra*.

<sup>55</sup> (1923) CPD 148.

<sup>56</sup> HPCSA Guidelines for Good Practice in the Healthcare Professions, South Africa.

<sup>57</sup> *Ibid*.

<sup>58</sup> National Patient's Right Charter 1988.

<sup>59</sup> Guideline-on-informed-consent-jul012.pdf available at <<https://www.samedical.org>> Accessed on 9<sup>th</sup> July, 2021.

<sup>60</sup> *Ibid*.



A person who is older than 18 years may equally consent to any operation<sup>61</sup>. Schools, whether they are public or private, may not test learners without the consent as required by the Child Care Act and it is likely that, even if consent is obtained in the school setting, such tests may be found to violate the human rights of the learners concerned<sup>62</sup>.

A teacher will also not be able to provide consent on behalf of a learner. Where research with, for example, HIV drugs is concerned, it is suggested that both parental and children's consent is obtained. In the case of mentally-ill persons, the curator, spouse, parent, major child or brother or sister, or the superintendent must consent on their behalf. If a person is temporarily incapable of providing consent, the general principle is that such a person should first be restored to a state where s/he can consent. In the case of a lengthy operation there may be a need to test the person<sup>63</sup>.

The consent requirement could be dispensed with if the defence of necessity (need to commence PEP treatment for a health care worker) and the requirements of the constitutional limitation clause as stated above are met. The HPCSA suggest that vicarious or proxy consent should be obtained from such a patient's closest relative<sup>64</sup>. Prisoners (i.e. arrested, detained, awaiting trial and sentenced prisoners), like any other person, have to consent to HIV tests and should be given pre- and post-test counselling as was held in (*C v Minister of Correctional Services*, 1996)<sup>65</sup>. The issue of informed consent therefore becomes pertinent in the multi-cultural setting. Language and cultural barriers may thus prevent patients from expressing their concerns or from asking questions on HIV tests. Medical practitioners should ensure that a patient has actually consented, as these barriers may result in the consent actually not being provided freely and voluntarily.

According to a report by the South African Human Rights Commission<sup>66</sup>, Australian guidelines provide that a patient should be told if an interpreter is available. In emergency cases where an interpreter is not available, a telephone interpreter service should be utilised and that all staff members that act as (non-professional) interpreters should receive appropriate training<sup>67</sup>.

As the South African Constitution provides for equality of languages, the South African Medical Association believes that there is a duty on the state to provide for (policies on) interpreting or at least for proper training for staff acting as interpreters. A general poster in a ward or consultation room that "all patients will be tested for HIV" does not constitute informed consent. It is also not recommended that a patient be merely provided with a leaflet or just referred to another institution to explain to him/her what the HIV test is about<sup>68</sup>.

It is often argued that in emergencies, one may dispose of the requirement of informed consent if it is necessary to save a patient's life. This is, however an unlikely situation and the circumstances may be too vague for a practitioner to defend him/herself against claims against not obtaining informed consent especially in developed medico-legal jurisdictions like South Africa. Thus, that a woman presents herself without clothes will be no defence to the charge of rape.

If there is a needle-stick injury and the patient is not willing or not capable to consent, it is possible to test an existing blood sample<sup>69</sup>. This should however not be the general policy or first line of reaction. This equally applies to occupational injuries as well. It should however be stressed that this will not prevent any patient from taking (legal) action against a medical practitioner in these circumstances.

If the South African Law Commission's proposals to incorporate some of the Australian policies on informed consent go through, it is submitted that the law will allow for rape suspects to be tested for HIV without their consent. This duty is likely to be performed by the District Surgeons or medical staff servicing prisons or places of detention, which has to verify that the detainee is in fact a rape suspect.

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<sup>61</sup> *Ibid.*

<sup>62</sup> *Ibid.*

<sup>63</sup> *Ibid.*

<sup>64</sup> HPCSA Guidelines for Good Practice in the Healthcare Professions, South Africa.

<sup>65</sup> (1996) 4 SA 292 (T).

<sup>66</sup> Guideline-on-informed-consent-jul012.pdf available at <<https://www.samedical.org>> Accessed on 9<sup>th</sup> July, 2021.

<sup>67</sup> National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research. 1979. *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research*. Washington, DC: US Government Printing Office. Available at: <<http://ohsr.od.nih.gov/guidelines/belmont.html>> Accessed 4th August, 2021.

<sup>68</sup> Guideline-on-informed-consent-jul012.pdf available at <<https://www.samedical.org>> Accessed on 9<sup>th</sup> July, 2021.

<sup>69</sup> *Ibid.*

#### IV. FORMS OF CONSENT

To be informed, consent must be given by persons who are competent to consent, have consented voluntarily, are fully informed about the research and have comprehended what they have been told. Unless they are emancipated minors, individuals under 18 years may never give consent. Also, question the legal competence of people affected by mental illness, or institutionalized in the prison system. If a person is not legally competent to give consent, a parent or legal guardian has to give it. The participant may still give assent.<sup>70</sup>

There is no statute that defines the categories of consent in Nigeria. However, in practice, consent to medical treatment may be express or implied:

(i) Express Consent: Consent is said to be express where a patient either by written or oral means agrees to a medical treatment or procedure to be carried out on him or her. Express Consent is important in conditions or procedure which has attendant risk, for instance: Surgery which requires administration of anaesthetic; Procedure which involves extensive gynaecological examinations or cases of major diagnostic procedure. In the above situation, written consent is preferable, but adequate information and explanation of the procedure must be explained by the physician in order for the patient to make an informed decision. Therefore, a witness is required to attest to such consent, the person could be a family member or members of staff of the hospital<sup>71</sup>.

(ii) Implied Consent: Implied consent comes to play with the action or demeanour of the patient in agreeing to take part in a procedure or treatment. Implied consent is more common in medical or general practice. Where a patient walks into a hospital, stretches out his hands for a procedure or examination without uttering a word but just action, is a form of implied consent. Implied consent is limited in nature as it applies only to minor procedures<sup>72</sup>. Where invasive procedure or examination is to be carried out on a patient, a written consent must be obtained after a detailed explanation of the importance of such procedure or treatment has been given to the patient. However, in cases where implied consent is in doubt, a verbal consent is imperative<sup>73</sup>.

There are however other kinds of consent, but the most prominent is the extra verbal consent.

Extra Verbal Consent: Extra verbal consent needs to be obtained where implied consent is in doubt especially in cases where sensitive and private parts of the body such as the breast or genitals are to be examined. Procedures where verbal consent is imperative include: Insertion of urethral catheter; Chest x-ray; Insertion of intravenous cannula; Wound dressing; Insertion or removal of drainage tubes; examination of genitals; breast or rectum; Insertion of Nasogastric tubes.

Furthermore, informed consent can only be given by a competent adult in the right mental state. In the case of a minor or other person incapacitated in mind or body, a close relative, guardian in *locus parentis* may sign on behalf of such patients but the interest of the minor must be paramount. The absence of a statute defining the nature of consent that medical personnel are required to obtain implies that disputes as to issues of consent would be addressed on the basis of standard professional practice and not by what the law provides<sup>74</sup>. Therefore, obtaining the consent of a patient is not a legal requirement but a standard professional practice.

##### 4.1 Capacity to Give Consent in Nigeria

A valid consent or a refusal to give consent requires a capability to make such decisions.<sup>75</sup> after adequate information has been given about the type of treatment or procedure, benefits, risks involved, alternative treatment if any and possible complication<sup>76</sup>. A competent adult with sound mind and body has the capacity to give consent to treatment or procedure to be carried out on him or her. However, where the examination or procedure involves marital issues such as sterilization, termination of pregnancy or removal of sex organs (breast or uterus) both couple must give their consent. However, it is noted that this is also not a legal requirement, but it is a desired practice. But an unconscious person, a minor or patient in an unstable state of mind may not be able to give a valid consent to treatment.

The general principle of law is that patients reserve the right to determine what treatment is to be administered to them<sup>77</sup>. Accordingly, in the case of *Chester v. Afshar*,<sup>78</sup> Lord Steyn posited that:

<sup>70</sup>Types of Consent. Available at <<https://cdn2.hubspot.net>> Accessed on 9<sup>th</sup> July, 2021.

<sup>71</sup> *Ibid.*

<sup>72</sup> *Ibid.*

<sup>73</sup> *Ibid.*

<sup>74</sup> National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research. 1979. *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research*. Washington, DC: US Government Printing Office. Available at: <<http://ohsr.od.nih.gov/guidelines/belmont.html>> Accessed 4th August, 2021.

<sup>75</sup>Pattinson, *supra*.

<sup>76</sup> Emiri, *supra*.

<sup>77</sup> J. Herring, *Medical Law and Ethics* (4<sup>th</sup> Ed, Oxford University Press, 2012) p.149

a rule requiring a doctor to abstain from performing an operation without the informed consent of a patient serves two purposes. It tends to avoid the occurrence of the particular physical injury the risk of which a patient is not prepared to accept. It also ensures that due respect is given to the autonomy and dignity of each patient.

Again, the common law has long recognised the right to self-determination by every individual to wit: "the right of every person to have his or her bodily integrity protected against invasion by others."<sup>79</sup> The English law insists that a patient's consent must be an "informed consent" for his autonomy to be said to have been preserved. Also, for consent to be valid, it must be shown that the patient has the capacity to consent and that the consent was given voluntarily having understood the nature of the treatment.<sup>80</sup>

#### 4.2 Unconscious Patients

An unconscious patient has no capacity to give consent but it is presumed that if he were capable of giving such consent, he will do so to save his or her life. In this circumstance, the Doctrine of Necessity will apply. In criminal and civil law, the doctrine of necessity gives legitimacy to an otherwise wrong act but the intention is of paramount importance, which is- to save or preserve a human life.<sup>81</sup> Therefore, a physician who carries out a procedure or treatment on an unconscious patient to save his/her life should not incur criminal liability; hence necessity is a defence for non-consensual treatment especially in an unconscious patient.<sup>82</sup> Notably, a physician should not take undue advantage of the unconscious state of a patient to carry out a procedure more extensive than what is immediately required to save the life of the patient. This position was established in two renowned Canadian cases where a distinction was made between procedures justified by necessity and that of mere convenience. In *Marshall v Curry*,<sup>83</sup> the plaintiff sought for damage for battery against a surgeon who removed a testicle in an operation of hernia. The surgeon claimed that the testicle was diseased and would affect the life of the patient if not removed immediately. The court held that the action of the surgeon was necessary at the point. However, in the case of *Murray v Mc Murdy*,<sup>84</sup> the action of battery succeeded where the surgeon sterilized a female patient by removing her uterus without her consent during a caesarean section operation. The court held that the procedure of sterilization is not detrimental to the life of the patient and could be decided later. Therefore, a physician in the course of duty must obtain a valid consent before invasive procedures or treatments are carried out on a patient to avert criminal liability.

However, when a patient has, after taking due cognisance of all the contextual elements as required by the law, been declared as lacking capacity, a decision can be made on the person's behalf only in accordance with his "best interests". Yet in line with its context-specific approach, the English law expects that in evaluating the patient's "best interests" wide assumptions should as best as possible be excluded; that the "specific circumstances" of the patient – and not the popular sentiment as to what is in a man's best interests<sup>85</sup> – should be considered.

#### 4.3 Consent of a Child/Minor.

With regards to children, the *Mental Capacity Act*<sup>86</sup> is not the regulating law rather; the *Children Act*<sup>87</sup> as was aptly seen in the case of *B Local Authority v. RM*.<sup>88</sup> English law refuses to outrightly deny children the right to take decisions, but categorises children into two: those below 16 years and those of 16 and 17 years. This represents an attempt to achieve a compromise between the enduring tradition that adjudges all persons below 18 as children and the pragmatic consideration that at some point, drawing the line between childhood and adulthood could be an uncertain task. This, in the opinion of this study, is commendable as it is another way of avoiding an absolute definition of "lacking capacity" in terms of age. However, the case of *Gillick v. West Norfolk and Wisbech Area Health Authority*<sup>89</sup> has been much more radical in this regard, as it has extended the potential for capacity even to children below the age of 16. This, arguably, may have struck some balance

<sup>78</sup>[2004] UKHL 41, para 18.

<sup>79</sup>J.K Mason & G.T Laurie, *Law and Medical Ethics* (9<sup>th</sup> Ed, Oxford University Press, 2013) pp.70-71

<sup>80</sup>E Jackson, *Medical Law Text, Cases, and Materials*, (2<sup>nd</sup> Ed, Oxford University Press, 2006) p. 181

<sup>81</sup>J.K Mason & Mc Call Smith 'Law & Medical Ethics' (7<sup>th</sup> Edn Oxford University Press 2006) 350-411.

<sup>82</sup>D.W Brock 'Children for Health Care Decision Making' in J.A Dada 'Legal Aspect of Medical Practice in Nigeria.

<sup>83</sup>{1949} 2 DLR 442.

<sup>84</sup>(1935) 2 ZACC 157.

<sup>85</sup> Medical Protection Society, 2013. Also, the Mental Capacity Act, 2005 provides that 'Exactly what is in someone's best interests will depend upon his/her specific circumstances and is not confined to purely medical'.

<sup>86</sup> 2005, c. 9.

<sup>87</sup> 2004, c. 31.

<sup>88</sup>[2010] EWHC 3802.

<sup>89</sup>[1986] AC 112; [1985] 3 All ER 402

between the traditional age-based yardstick for measuring wisdom and the pragmatic approach which recognises that circumstances such as intellectual gift, level of exposure, family background and specific context of decision-making could enhance capacity irrespective of age. Similarly, the *Gillick* test may have made some allowance for variations in cognitive strength not uncommon among people of the same age group and for the fact that a child who may lack capacity in one instance may have capacity in another instance.<sup>90</sup>

It is further noted that the ability to give consent is not limited to the statutory age of majority as the constitution of the Federal Republic of Nigeria prescribes 18 years as age of majority where a citizen can exercise his/her franchise.<sup>91</sup> With regards to decision making on behalf of a child under the Nigerian legal system, the best interests of that child shall be primarily considered. This is provided for in Article 4 (1) of the African Charter on the Rights and Welfare of a Child<sup>92</sup> which has been entrenched in the Child's Right Act to wit:

*In every action concerning a child, whether undertaken by an individual, public or private body, institutions of service, court of law, or administrative or legislative authority, the best interests of the child shall be the primary consideration.*<sup>93</sup>

In medical examination or treatment, a competent minor of less than the statutory age of majority can give a valid consent in as much as he/she is fully informed and totally understands the implication of such treatment or procedure. It is believed that parents have the capacity and wisdom to make accurate and informed decisions that affect the lives of their children.<sup>94</sup> This may be premised on the fact that parents bear the long-time effect or consequences of choice of treatment on behalf of their children.<sup>95</sup> In spite of the rights of parents to take decision on behalf of incapable minors, they do not have the legal right to solely make decisions regarding some medical procedures such as sterilization and removal of vital organs of a living child for donation, as well as choosing for the minor the right to die-martyr or approve euthanasia- 'mercy-killing' for their children.<sup>96</sup> It means that parents' rights to make decisions on behalf of their children are not sacrosanct. However, in the case of a mature minor who has the capacity to understand the choice of treatment and its consequences, then he/she can give a valid consent to care as though he were an adult.

This principle of a mature minor was determined in the Supreme Court case of *Re Ernestine Gregory*.<sup>97</sup> In that case, Ernestine, a 17year old Jehovah's Witness was on admission for Leukemia- a medical condition: cancer of the blood resulting in frequent breakdown of the blood cells in the body and the age of maturity in Illinois was 18years. He refused blood transfusion as it was against his faith; his mother was in support of his decision. Because he was a minor, the Child Welfare Officials in Chicago sued his mother for medical negligence. The trial court ordered blood transfusion in spite of the evidence that the patient had sufficient maturity to make such decision. The patient appealed against this decision. The Court of Appeal affirmed the decision of the mature minor. The Supreme Court also re-affirmed the position of the appellate court and overruled the decision of the trial court on the ground that the patient has shown enough competence to make such decision and hence cannot be forced to submit to blood transfusion, his right of self-determination must be respected. In addition, it is established under Common Law that parents in the absence of neglect or incapacity make all the necessary choices as it pertains to the well-being of their children.<sup>98</sup>

Furthermore, there are essentials that must be taken into consideration in implementing the best interest principle, they include: Is the decision likely to improve the condition of the child? ; Can the treatment prevent further deterioration of the child's condition?; If the benefit involved in the treatment outweighs the risks on the child?; Whether there is an option of a less invasive treatment?

#### **4.4 Persons with Mental Incapacity**

A person with a sound body and mind is presumed competent to give informed consent in Nigeria and South Africa like most nations of the world. However, patients with mental diseases or impairment may be incapable of giving informed consent to treatment or medical procedures. Mental impairment could also be due to dementia arising from degenerative processes in the brain as a result of aging process. Davis classified lack of

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<sup>90</sup>U. Arinze.(2005) Decisions made on Behalf of those who Lack Capacity (in the Medical Context) Under the English and Nigerian Legal Systems. NAUJILJ Vol. 6 p.186 available at <<https://www.ajol.info>> Accessed 30th July, 2021.

<sup>91</sup> 1999 Constitution of the Federal Republic of Nigeria.

<sup>92</sup> African Charter on the Rights and Welfare of a Child, ACRWC, July 1999.

<sup>93</sup> Child's Right Act, Cap 2003.

<sup>94</sup>F. O Emiri 'Medical Law and Ethics in Nigeria' (Malthouse Press Ltd. 2012} p304.

<sup>95</sup> Dada, *supra*.

<sup>96</sup>*Re T* (1992) WLR 782, 4 ALL ER 649.

<sup>97</sup>*Re Ernestine Gregory* 133 IU 2d 98549 NE 2d 322(1989).

<sup>98</sup> Dada, *supra*.



competence as temporary (in children); transient (as in unconscious patients); or permanent (in some mentally handicapped patients, except the patient is in the lucid stage where he is capable of understanding the information given to him.<sup>99</sup> The issue therefore would be to determine when a patient is competent to give informed consent to treatment or surgical procedure and the test would be that of a reasonable man.

Therefore, to determine whether or not patients are given their rights to informed consent in Nigeria sufficiently and under different circumstances and legal stipulations, a comparative analysis of both Nigeria and South African legal jurisdiction and healthcare systems is desired in order to identify the differences and making the Nigerian legal system learn from her South African counterpart.

## V. COMPARATIVE ANALYSIS OF THE NIGERIAN AND SOUTH AFRICAN HEALTH SECTOR'S PATIENTS' INFORMED CONSENT

Informed consent before medical procedures is constitutionally protected right in South Africa. This is not the same in Nigeria. This was demonstrated in the case of *Minister of Safety and Security v. Xaba*<sup>100</sup>. Here the police wanted a court order to compel an accused person to undergo a surgical procedure in order to obtain a bullet to be used in evidence against the accused. The Court refused this request; arguing that such an order would violate the defendant's constitutional rights to bodily and psychological integrity, including the right to security and control of one's body<sup>101</sup>. Patients consent, as a requirement for all lawful medical interventions, is a well-established principle in South African common law<sup>102</sup>. The earliest cases in this area were *Stoffberg v. Elliot* 1923<sup>103</sup> and *Esterhuizen v. Administrator Transvaal* 1957<sup>104</sup>. In the former case a patient whose member was wrongfully amputated due to penile cancer without informed consent, sued his doctors for damages in action for assault. While instructing the jury, Watermeyer J opined that:

In the eyes of the law, every person has certain absolute rights, which the law protects. They are not dependent upon a statute or upon a contract, but they are rights to be respected, and one of those rights is the right of absolute security of the person....Any bodily interference with or restraint of a man's person which is not justified in law or excused by law, or consented to, is a wrong, and for that wrong the person whose body has been interfered with has a right to claim such damages as he can prove he has suffered owing to that interference.

In the case of *Esterhuizen v. Administrator Transvaal*<sup>105</sup>, a 10-year-old child diagnosed with Kaposi's sarcoma was initially treated with superficial radiation with her parents' consent. However, following recurrence of the tumour she was subjected to radical radiation therapy which resulted in severe burns necessitating amputation of her limbs. The Court held that while the superficial radiation was duly performed with appropriate consent from the parents, the latter procedure was performed without the informed consent of the child's guardians. The court rejected the defence arguments for implied consent based on the fact that her parents had previously consented to a similar treatment, as well as arguments that the treatment was in the child's best interest. Holding that because the radical treatment was vastly different from the prior superficial radiation, it was necessary that the child's parent should have been adequately informed of the dangers inherent in the new treatment, before such consent to be considered valid<sup>106</sup>. A more recent judgment in the case of *Castell v. DeGreef*<sup>107</sup> by Ackerman J seems to have consolidated the doctrine of informed consent into South African jurisprudence. The consequences of the latter decision on South African medical law were that the following principles have generally been adopted into the clinical practice of medicine locally and this is hoped would form part of the Nigerian medical jurisprudence in the coming years. They include:

‘a shift from medical paternalism to patient autonomy; a shift from the 'reasonable doctor' standard to the 'prudent patient' standard; a shift in disclosure to the 'material risk' standard, where the level of disclosure required is what a reasonable patient would consider pertinent before making a decision.

It has thus been suggested that the Court appears to place the patients' informed consent within the framework of *volenti non fit injuria* or voluntary assumption of risk rather than delict<sup>108</sup>. The National Health Act (NHA)

<sup>99</sup>M. Davies *Textbook on Medical law* (1998 Blackstone Press Ltd. London) 131-139.

<sup>100</sup>*Minister of Safety and Security v. Xaba* [2003] (2) SA 703 (D).

<sup>101</sup>*Ibid.*

<sup>102</sup>F.F.W Van Oosten, *The Doctrine of Informed Consent in Medical Law*. LLD Thesis. 1989, University of South Africa, School of Law, pp 45-101.

<sup>103</sup>*Stoffberg v. Elliot* [1923] CPD 148-150.

<sup>104</sup>1957 (3) SA 710 (T).

<sup>105</sup>1957 (3) SA 710 (T).

<sup>106</sup>*Ibid.*

<sup>107</sup>*Castell v. DeGreef* [1993] (3) SA 501.

<sup>108</sup>P. Carstens, D. Pearmain, *Foundational Principles of South African Medical Law*. 2007, Durban: LexisNexis 76.

promulgated in 2003<sup>109</sup> codified the requirements for informed consent into South African law. Section 7 of this Act stipulates that health services may not be provided to a healthcare user without the user's informed consent, unless "the user is unable to give informed consent and such consent is given by another person, mandated by the user in writing to grant consent on his or her behalf; or authorized to give such consent in terms of any law or court order; or where the user is unable to give informed consent and no person is mandated or authorized to give such consent"<sup>110</sup>. The law further requires that every health care provider must inform a user of "the user's health status except in circumstances where there is substantial evidence that the disclosure of the user's health status would be contrary to the best interests of the user"<sup>111</sup>. Section 6 of the NHA stipulates that information disclosed to patients must include the following:

- (a) The range of diagnostic procedures and treatment options generally available to the user.
  - (b) The benefits, risks, and consequences generally associated with each option; and
  - (c) The user's right to refuse health services and explain the implications, risks, obligations of such refusal<sup>112</sup>.
- The NHA also requires that the health care providers must inform the user of this information in a language that the user understands and in a manner which takes into account the user's level of literacy. This particular requirement is an improvement over what is obtainable in Nigeria.

The nature of informed consent is equally better developed in South Africa than what is obtainable in Nigeria. Informed consent which as an autonomous authorisation by individuals of a medical intervention takes a complementary view of informed consent as a conversation that follows specific rules<sup>113</sup>. In South Africa, such conversation is ideally initiated by the physician or healthcare professional and involves transparency, engagement by both parties, and continues throughout the period of healthcare intervention. This conversation also requires evidence that it occurred in the form of a witnessed signature, co-signed consent documents, or medical progress notes<sup>114</sup>. As a general rule however, medical treatment does not proceed in South Africa unless the doctor has first obtained the patient's consent which may be either express or implied. The consent given by a patient may equally be withdrawn at anytime<sup>115</sup> and could be vitiated by any change in circumstances, which are not communicated to and approved by the individual consenting.

Also in South Africa, the requirement for validity of patients' consent is better developed. Generally, for consent to be considered valid or truly informed, five (5) key requirements must be fulfilled and they include<sup>116</sup>:

- (a) Information disclosure: provision of adequate information
- (b) Competence: capacity to understand that information;
- (c) Voluntariness: decision making in the absence of coercion or deception;
- (d) (Comprehension: understanding of information provided and
- (e) (Consent: agreement to the proposed treatment or procedure.

It is also noted that informing the patient in South Africa is not simply a ritual recitation of the contents of a written document as is practised in Nigeria. Rather the healthcare professional tries to convey the information, whether orally or in writing, in language that suits the individual's level of understanding<sup>117</sup>. The healthcare professional obtaining consent in this jurisdiction thus bears in mind that the prospective subject's ability to understand the information necessary to give consent depends on that individual's maturity, intelligence, educational level, and belief system. It also depends on the clinician's ability and willingness to communicate with patience and sensitivity<sup>118</sup>. According to the US District Court of Appeal in *Canterbury v. Spence*<sup>119</sup>, the

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<sup>109</sup> National Health Act 61 of 2003: Government Gazette. 2004, 469 (26595).

<sup>110</sup> *Ibid.*

<sup>111</sup> *Ibid.*

<sup>112</sup> *Ibid.*

<sup>113</sup> T.R McCormick, *Informed Consent, Its basis, Problems, Uncertainties*. 1998, University of Washington School of Medicine. <<http://depts.washington.edu/bioet>> Accessed 12th July, 2021.

<sup>114</sup> *Ibid.*

<sup>115</sup> *Ciarlariello v. Schactr* [1993] 100 DLR (4th) 609 SCC.

<sup>116</sup> R.M Nelson, T. Beauchamp, V.M Miller, W. Reynolds, R.F Ittenbach, M.F Luce, *The Concept of Voluntary Consent*. *AJOB*. 2011, 11: 6-16.

<sup>117</sup> F. Tekola, S.J Bull, B. Farsides, M.J Newport, A. Adeyemo, C.N Rotimi, G. Davey, *Tailoring Consent to context: Designing an Appropriate Consent Process for a Biomedical Study in a Low Income Setting*. *PLoS Negl Trop Dis*. 2009, 7: e482.

<sup>118</sup> *Ibid.*

patient's right to self-determination can be effectively exercised only if the patient possesses enough information to enable intelligent choice...True consent to what happens to one's self is the informed exercise of choice and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each. From these axiomatic considerations springs the need, and in turn the requirement, of a reasonable divulgence by the physician to the patient to make such a decision possible and it is hoped this practice would be imbibed in the Nigerian health sector.

It was further asserted in the case of *Salgo v. Leland Stanford University* that: "A physician may violate his duty to his patient and subject himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to proposed treatment". Because of this potential for violation of patient's rights and dignity during the informed consent process, it has been suggested the quality of informed consent given by patients during various clinical encounters, should be scientifically investigated for validity, completeness, and consistency with established ethical and legal principles.

Another distinction in the patient informed consent between the two (2) countries is the extent of challenge posed by language barrier. Currently South Africa has 11 official languages, unlike Nigeria with only 1 official language- English language. Nigeria, though multi-lingual still has an acceptable mode of communication in our hospitals- English language or the local language of the dwellers. Thus, language barriers, especially the absence of adequately trained interpreters to assist healthcare professionals in providing care to patients is a major problem in South Africa and Nigeria. In a study at a South African district hospital<sup>120</sup>, the authors concluded that language barriers in hospitals create significant problems for healthcare professionals and can impact negatively on patients' rights to confidentiality, informed consent and the quality of healthcare service delivery<sup>121</sup>. Other cultural barriers identified by doctors in the study include different cultural beliefs about blood transfusion and amputations. The impact of family members in decision-making, especially husbands within the traditional African cultural ethos also equally affect both countries. All of these are deemed as barriers to the appropriate practice of informed consent in both countries. To further improve understanding and comprehension during the informed consent process, the US National Bioethics Advisory Commission (NBAC) has suggested that community participation is acceptable, which may include providing written information sheets for discussions with family members and holding community meetings, but cautions that family permission should not replace the requirement for individual informed consent.

## VI. CONCLUSION

In conclusion, it is noted that everyone has a right to be given full and accurate information about the nature of his or her ailment, the diagnostic procedures involved, the proposed treatment; the costs involved and the possible risks associated with the administration of drugs or other treatment on him/her, so an informed decision to receive or not can be made. The elements of patient-informed consent as practiced in the better developed medico-legal jurisdiction liked South Africa which includes that it must be voluntary and without constraint; written or implied especially for HIV tests; that it must not conflict with good morals or the constitution; that the patients must be capable of giving valid consent, (either personally or by proxy); the patients having a thorough understanding of why the medical practitioner needs the results of the test and availability of sufficient information on the diagnosis, proposed treatment, expected benefits, risks, alternative treatment, probable results, etc must be imbibed and practiced in Nigeria. The patients must also actually understand everything or at least arrangements must be made to assist the process of understanding, so the medical practitioner does not raise a defence of defective understanding capacity on the part of the patient. Better medical and forensic training must also be organised for the judiciary and other law enforcement agents, so they can better understand the dynamics of patient-informed consent and better address often complex legal issues requiring medical and forensic evidence around medical negligence.

Equally, it is noted from the evaluated studies on informed consent in Africa, most especially Nigeria, that whilst many doctors are generally knowledgeable about the ethical doctrine of informed consent in principle, the application and adherence to the legal and ethical requirements is normally lacking in practice unlike in South Africa where it is taken very seriously, it is thus hoped that Nigerian doctors can and other health practitioners can take a cue from their South African counterparts.

It is also worthy of note that part of the major challenges militating against the proper practice of informed consent in Nigeria include medical paternalism (the 'my doctor knows best' syndrome), lack of education of patients, language barriers, insufficient administrative support, most especially patient interpreters

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<sup>119</sup> [1972] 464 2d 772 (DC).

<sup>120</sup> F. Tekola, S.J Bull, B. Farsides, M.J Newport, A. Adeyemo, C.N Rotimi, G. Davey, Tailoring Consent to context: Designing an Appropriate Consent Process for a Biomedical Study in a Low Income Setting. *PLoS Negl Trop Dis.* 2009, 7: e482.

<sup>121</sup> *Ibid.*

and Geriatric doctors to attend to aged patients, large patient numbers, excessive workload and time constraints within which to ask the requisite consent questions which affect the South African health sector also affects the Nigerian healthcare sector, but only in a wider proportion.

Irrespective of the attendant challenges, Nigeria must still be ready to learn and understudy the mechanisms for patient-informed consent, in order to learn vital lessons from the South African medical parlance's advanced legal and medical healthcare systems, so as to construct a competent, viable, sustainable and worthwhile legal and regulatory framework to encourage the stimulation of patient-informed consent in Nigeria.

It is thus recommended that there should be a massive recruitment and training of interpreters as part of medical teams in both Nigerian and South African hospitals, to assist in improving the quality of doctor-patient communications, informed consent, improved confidentiality, and healthcare service delivery in all hospitals.

It is further recommended that the current universal hospital consent form be swiftly modified to better reflect current teaching in medico-legal practice, by including translations in local languages, or options for specific consent for certain procedures or mandatory disclosures as required by law.

It is equally advocated that patient information leaflets are produced in local languages to enhance patient education and understanding prior to providing consent., whilst continuing education for doctors and other healthcare professionals in ethics and medical law will go a long way towards improving the overall quality of healthcare service delivery in Nigerian and South African hospitals.

Finally, better and further study is advocated to fully identify the differences and similarity between the legal and medical jurisprudence of Nigeria and South Africa most especially regarding patient-informed consent, so Nigeria can properly glean lessons from the South African jurisdiction.

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