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# Patient's Freedom and Informed Consent in Nigeria: A Symbiotic Relationship

IBITOYE, T. R. *

**Abstract**

The fundamental rights of a patient to freedom or autonomy and informed consent are two symbiotic concepts that regulate the relationship between a doctor and a patient. A patient's right-to-know and determine his health issues is not just ethical principles but legal obligations of a doctor to his patient which increases the latter's confidence in his doctor and the entire health-care team. Although both rights are independent, they are also symbiotic in nature; and the enjoyment of one right results in the enjoyment of the other while the deprivation of one causes the denial of the other. Therefore, this article shall examine the dual concepts of autonomy and informed consent; the limitations and exceptions to the doctrine of informed consent; the symbiotic relationship between a patient's autonomy/freedom and informed consent. and conclude by recommending how the symbiotic relationship between both concepts can be strengthened and enjoyed better in Nigeria.

**Keywords:** Medical Ethics, Patient's Freedom, Patient's Autonomy, Informed Consent, Symbiotic Relationship.



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**Introduction**

According to Article 25 (1) of the United Nations Universal Declaration of Human Rights:[1]

> Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services…

This means that so long as a patient is a human being, he/she has some rights enshrined by the law in his/her favour. One of such rights is the right to standard health and medical care. Furthermore, embedded in a patient's right to health are some other ethical principles, such as right to freedom/autonomy and informed consent. On the other hand, these rights enjoyed by a patient are obligations imposed on a medical practitioner in the course of treating the said patient.

Freedom, also known as autonomy, and informed consent are sister rights of a patient, that although independent are at the same time interrelated and symbiotic with each other. Both are independent in the sense that, while the former relates to the capacity of a patient, preferably an adult, to decide or determine what shall be done to his own body, the latter is about the enjoyment of a patient's right to be told or have knowledge about his/her medical condition and treatment. However, both concepts are connected or interrelated as one cannot successfully exist without the other because the enjoyment of one leads to the other and the deprivation of one is the denial of the other. In other words, a patient cannot enjoy his/her right to decide whether to accept or refuse a treatment (autonomy) if he/she is not given sufficient information about his/her medical status, the available treatment, the risks and benefits of the treatment, and the alternative treatment (informed consent). Thus, informed consent leads to/produces an autonomous patient.

Unfortunately, in Nigeria several cases investigated by the Medical and Dental Practitioners Investigating Panel show that many practitioners are oblivious of what a proper consent should be[2]. For instance, Jebbin and Adotey reviewed patients admitted for surgery at the University of Port Harcourt Teaching Hospital and they found that, although 74.6% of the patients studied were informed of their diagnosis, only 36.7%

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1 United Nations. *The Universal Declaration of Human Rights.* Retrieved December 09, 2017 from www.ohchr.org/EN/UDHR/Documents/UDHR_Translations/eng.pdf

2 Rule 19 of the Rules of Professional Conduct for Medical and Dental Practitioners in Nigeria, also known as, Code of Medical Ethics in Nigeria. 1995. Retrieved December 09, 2017 from http://www.mdcnigeria.org/Downloads/CODE%20OF%20CONDUCTS.pdf.

were informed of the possible complications of the surgery, while only 26% knew the complications that could arise from anaesthesia. Also, consent forms were signed by only 35% of respondents[3].

This denial of informed consent is partly due to the fact that there is no standard format for obtaining consent for procedures and surgical interventions on patients in Nigeria and because there are indeed practitioners who do not insist on formal consent to intervene on the body of the patient, for adequate ethical protection[4]. Hence, this article shall examine the dual concepts of autonomy and informed consent; the limitations and exceptions to the doctrine of informed consent; the symbiotic relationship between a patient's autonomy and informed consent; and conclude by recommending how the symbiotic relationship between both concepts can be strengthened and enjoyed better in Nigeria.

**Patient's Autonomy/Freedom**

The term, "*autonomy*" is a word of Greek origin, as it comes from the Greek word "*eautos*" which means self, and the word "*nomos*", which means rule, governance or law. The term "*autonomy*" is used in the English language for describing a person's capacity to express freely his/her will, or his/her capacity and freedom for action in a particular society[5]; but it is a complex term subject to several interpretations.

In *Schoendorff v. Society of New York Hosp.,*[6] the libertarian principle of self-determination was established by Cardozo CJ, when he held that "Every human being of adult years and sound mind has a right to determine what shall be done with his own body, and a surgeon who performs an operation without the patient's consent commits an assault". This long-standing common-law principle recognises and protects human autonomy, and also forms the foundation on which the doctrine of informed consent rests. Walker and Blechner also defined respect for patient's autonomy as the core legal and ethical principle that underlies all human interactions in health care. Every adult

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3 Jebbin, N.J. and Adotey, J.M. 2004. Informed Consent: How Informed are Patients? *Niger J Med,* 13: 148–151.

4 Op cit, n. 2: 27.

5 Leino-Kilpi, H., Välimäki, M., Arndt, M., et al. 2000. Patient's Autonomy, Privacy and Informed Consent. *Biomedical and Health Research.* Amsterdam: IOS Press. 40.

6 (1914) 105 NE 92. In the above case, the plaintiff, Mary Schloendorff, was admitted to New York Hospital and consented to being examined ether to determine if a diagnosed fibroid tumour was malignant, but withheld consent for removal of the tumour. The physician examined the tumour, found it malignant, and then disregarded Schloendorff's wishes and removed the tumour. The court found that the operation to which the plaintiff did not consent constituted medical battery.

human being of sound mind has a right to determine what shall be done with his own body and he/she has the right and responsibility to make health-care decisions.[7]

Furthermore, autonomy can be defined as autonomy as "a set of diverse notions including self-governance, liberty rights, privacy, individual choice, liberty to follow one's will, causing one's own behaviour and being one's own person".[8] Also, the respect for patient's autonomy presupposes that patients should be informed about possible alternative treatments.[9]

Patient autonomy includes confidentiality and their right to privacy regarding their body, health information and their decisions. When they choose to surrender some of their privacy, they expect that what they say or what is done to them is kept confidential.[10] Hence, autonomy is a patient's ability of self-rule and self-determination of his medical rights relating to his/her treatment, based on his/her religion, background and legal capacity.

In Nigeria, the case of *the Medical and Dental Practitioners Disciplinary Tribunal v. Okonkwo*[11] identifies the right of a patient to self-determination. In that case, Mrs Martha Okorie, who had a delivery at a maternity on 29th July, 1991, was admitted as a patient at Kenayo Specialist Hospital for a period of 9 days from 8th August to 17th August, 1991. She had difficulty in walking and severe pain in the pubic area. At Kenayo Hospital, a diagnosis disclosed a severe ailment and, a day after her admission, blood transfusion was recommended. The patient and her husband, Loveday Okorie, refused to give informed consent to blood transfusion on religious grounds, being members of a sect known as Jehovah's Witnesses, which regards blood transfusion as forbidden by God. Dr Okafor issued her a certificate of discharge and was taken away by her husband on 17/8/91. She was, however, taken to the respondent of Jeno Hospital. The respondent, who is a member of the Jehovah's Witnesses' sect, proceeded to treat the patient without transfusing blood. She died on 22nd August, 1991.

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Walker, L. and Blechner, B. 1995-96. Continuing Implementation of the Patient Self-Determination Act in Nursing Homes: Challenges, Opportunities, and Expectation. *Generations,* 19.4: 73.

Smith, J.A. 1994. Ethical Considerations of Giving Patients Choices. *Hospital Topics.* 72.3: 15-20.

Barer, D. 1997. Respect for Autonomy May Conflict with Principle of Beneficence. *BMJ.* 315: 254.

Harish, D., Kumar, A. and Singh, A. 2015. Patient Autonomy and Informed Consent: The Core of Modern Day Ethical Medical. *J Indian Acad Forensic Med.* 37.4: 412. Retrieved December 09, 2017 from http://medind.nic.in/jal/t15/i4/jalt15i4p410.pdf

[11] [2001] WRN 1. See also *Natanson v. Kline* (1960) 186 Kan. 393; and *In Re Osborne* (1972) 294 A.2d 372.

The respondent was charged before the court in 1983 on two counts. In the first count, he was charged with attending to the patient in a negligent manner, and thereby conducting himself infamously contrary to "Medical Ethics" and punishable under section 16 of the Medical and Dental Practitioners Act 2004. In the second count, he was charged with acting contrary to his oath as a medical practitioner and thereby conducting himself infamously in a professional respect contrary to section 16 of the said Medical and Dental Practitioners Act 2004. The allegations in the two counts were: (1) that the respondent "made no plans and in fact failed to transfuse blood to the patient until she died on 22/8/91"; (2) that the respondent "failed to transfer the patient to a bigger centre where such inhibition would not operate to the patient's disadvantage"; (3) it was clear that only blood transfusion could possibly save the patient's life, but because of his religious belief against blood transfusion, he "readily agreed with this patient's husband not to transfuse blood, even when the patient's relations pleaded with the respondent "to the contrary". There was, however, evidence before the Tribunal that the respondent had transfused blood to other patients of that religious sect who agreed and that one of the patient's relations was instructed to keep watch while the patient slept lest she be overpowered to have blood transfused to her. The Tribunal was, however, convinced that the consideration which influenced the respondent's treatment of the patient was the respondent's own religious belief. The Tribunal found the respondent guilty "on the 3 counts", and suspended him for a period of six months "on each of the charges", which are to run concurrently. However, the Supreme Court unanimously dismissed the appeal, and Ayoola, JSC held inter alia:

> The patient's constitutional right to object to medical treatment or, particularly, as in this case, to blood transfusion on religious grounds is founded on fundamental rights protected by the 1979 Constitution as follows: (i) right to privacy: section 34; (ii) right to freedom of thought, conscience and religious: section 35. All these are preserved in section 37 and 38 of the 1999 Constitution respectively. 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 limits of these freedoms, as in all cases, are where they impinge on the rights of others or where

> they put the welfare of the society or public health in jeopardy. 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…

Furthermore, in Nigeria, patients are frequently deprived of their right to freely decide what they want to be done to their bodies by their doctors, and often times, the latter practice the principle of paternalism in which they make decisions on behalf of their patients. Thus, patients and health-care professionals should have as their common goal the realisation and maintenance of the patients' capacity to be free and autonomous. Therefore, health-care professionals should make sure that patients understand the basics of their diagnosis and their proposed treatment and they have to help them feeling secure to refuse professional suggestions if they wish to.[12] Finally, to every general rule, there is always an exception, so, in spite of the fact that every individual has a right to choose what will be done to his/her body, his/her right is restricted by the autonomous rights of others. Therefore, a patient's right stops where that of others begins.

**Informed Consent**

Consent is based on the Latin maxim —*volenti non fit injuria* – to a willing person, no injury is done,[13] that is, one who knowingly and voluntarily consents to and takes on a risk ,cannot ask for compensation for the damage or injury resulting from it.[14] It may also be defined as —A free and voluntary agreement, compliance or permission given for a specified act or purpose.[15] Informed consent is all about a person's right to receive information about the availability of health services, about one's own condition and about applicable treatment, including information about the health-care providers.[16] It is

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[12] Nessa J. and Malterud K. 1998. Tell Me What's Wrong with Me: A Discourse Analysis Approach to the Concept of Patient Autonomy. *Journal of Medical Ethics*. 24.6: 394-402.

[13] Cornell Law School. Volenti Non Fit Injuria. Retrieved December 09, 2017 from https://www.law.cornell.edu/wex/volenti_non_fit_injuria

[14] BusinessDictionary. Volenti Non Fit Injuria. Retrieved December 09, 2017 from http://www.businessdictionary.com/definition/volenti-non-fit-injuria.html

[15] Op cit, n. 10: 413.

[16] Op cit, n. 5.

a process, which guarantees the patient's freedom, privacy and safety[17] which in turn ensures maintenance of trust between doctors and patients.

Furthermore, the World Health Organisation in "a Declaration on the Promotion of Patients' Rights in Europe"[18] examined the concept of informed consent as a patient's right and a prerequisite for any medical intervention. Therefore, the purpose of informed consent is for a doctor to respect his patient's autonomy and further enable him to make important decisions regarding his medical care.

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. 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.[19] Where informed consent is lacking, every touching of the patient is potentially battery.[20] It is a patient's consent, either implied or expressed, which makes the touching innocuous.[21] At law, no treatment is to be administered to a person without his consent merely because others reason that it is for his benefit.[22] In other words, a patient who possesses the capacity to give consent to treatment cannot be treated where he withholds his/her permission, even though his/her relatives or medical personnel find his/her decision to be unreasonable or dangerous to his/her health. Thus, any person who does would be treated as busybody that would expose him to actionable trespass.[23] In *R v. Williams,*[24] a 16 year old girl who had not been told anything about sexual matters was tricked into having sexual intercourse by a professional because he told her that it would improve her singing voice. It was held that because she could not have possibly consented to sexual intercourse, what she did consent to

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[17] Strom-Gottfried K. 1998. Informed Consent Meets Managed Care. *Health Soc Work.* 23.1: 25-33.

[18] World Health Organisation (WHO). A Declaration on the Promotion of Patients' Rights in Europe' European Consultation on the Rights of Patients. Retrieved December 09, 2017 from www.who.int/genomics/public/eu_declaration1994.pdf

[19] Op cit, n. 5: 26.

[20] Mason, J.K. and Laurie, G.T.1983. *Law and Medical Ethics.* 4th ed. London: Buttterworth, 112.

[21] Ibid.

[22] Baker, D. 2015. *Granville Williams Textbook of Criminal Law.* 4th ed. UK: Sweet and Maxwell. 1- 1494.

[23] Ibid.

[24] [1923] 1 KB 340.

that she did not have the freedom to choose whether or not to have sexual intercourse because she was not aware of what sexual intercourse was. Further, in *Sidaway v. Board of Governors of the Bethlem Royal Hospital*,[25] the Court held that a doctor operating without consent, except in emergency or a case of mental incapacity, commits trespass and criminal assault.

It is inferred from the cases above that an alleged consent based on deception, fraud, mistake or misrepresentation is vitiated, hence, no consent. However, as held in *R v Richardson*,[26] where a doctor is suspended from medical practice and continues practising, the consent to treatment obtained from his patient is valid. In that case, the appellant, a registered dentist, had her licence to practise suspended by the General Dental Council in 1996 but continued to treat patients, whom she did not inform of the suspension. On this basis, the appellant was charged with six counts of assault occasioning actual bodily harm. The judge at trial ruled against the defence submission that the patients treated by the appellant after her disqualification had consented to their respective procedures, noting that the fraud as to her credentials vitiated any such consent. On appeal, it was argued by counsel for the appellant that the judge at trial had erred in striking out the submission of the defence, in that not all deceptions amounted to fraud of a type that could vitiate consent; only those which spoke to the nature of the act itself or the identity of the person perpetrating the fraud were capable of doing so. The Court of Appeal also confirmed, allowing the appeal, that fraud only negatived consent in circumstances where the victim was deceived as to either the nature of the act performed or the identity of those performing it. As there was no deception as to the nature or purpose of the act, the consent was valid.

**Types of Consent**

Informed consent is mainly of two (2) types which are express and implied consent:

***Express Consent***

This is an unequivocal agreement to a medical procedure. This may be verbal or written. A verbal/oral consent is where a patient states consent to a procedure verbally but does not sign any written form. This is adequate for routine treatment such for diagnostic procedures and prophylaxis, provided that full records are documented.[27] Where

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[25] [1985] AC 871 at 87, 904.

[26] [1998] 2 Cr App 200.

[27] Mirza, A.M. 2012. Importance of Informed Consent in Dentistry. *Int Dent J Stu Res*. 1: 13–16. Retrieved December 11, 2017 from www.idjsr.com/article_html.php?did=1271&issueno=0.

verbal/oral consent is required, it is better to obtain such in the presence of neutral third parties like hospital staff or patient's family members. This is necessary to ensure credibility of patient's testimony in the occurrence of law suit.

On the other hand, a written consent is necessary in case of extensive intervention involving risks where anaesthesia or sedation is used, restorative procedures, any invasive or surgical procedures, administering of medications with known high risks, and so on.[28] Written informed consent may also be needed in case of following medical procedures: most surgeries, even when they are not done in the hospital as well as other advanced or complex medical tests and procedures. Examples are an endoscopy (placing a tube down your throat to look at the inside of your stomach) or a needle biopsy of the liver; radiation or chemotherapy to treat cancer; most vaccines; and some blood tests, such as HIV testing (need for written consent varies by countries).[29] Other situations include: cases of extensive gynaecological examination, or cases of major diagnostic procedure.

Generally, written consent is often preferable to verbal consent due to the gravity of what is involved and the possibility of subsequent denial by the patient. In Nigeria, a special written form designed by the Council of Medical and Dental Practitioners called "Approved Proforma for Obtaining Consent for Anaesthesia, Surgical Operations and Clinical Procedures"[30] is available in all hospitals.

It should be noted that forms of consent are not limited to expressed or implied methods. Technology has widened the horizon of consent to include those that can be given via telephone, e-mail, or even fax. However, these relatively new forms have not been fully embraced by Nigerian patients, particularly, the unlearned, learned but computer illiterates, and those living in the rural area. Thus, the Nigerian government should educate its citizenry on how to utilise technological gargets, and their benefits.

*Implied Consent*

This is the commonest form of consent in medical practice that is provided by the patient directly or indirectly through his/her conduct or misdemeanour suggesting that a patient passively cooperates in a process without discussion or formal consent.

The principles of good communication apply in these circumstances and health professionals need to provide

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[28] Ibid.

[29] Medline Plus. 2015. Informed Consent-Adults. Retrieved December 11, 2017 from https://medlineplus.gov/ency/patientinstructions/000445.htm.

[30] Op cit, n. 2: 28.

procedure and why it is being done. Implied consent does not need to be documented in the clinical record.[31] Examples of implied consent are when a patient enters a hospital and pays a doctor a fee for treatment; when he/she attends a doctor's appointment; when a patient extends his/her arm to provide a routine blood sample/injection; when a patient lies on a doctor's couch for examination; or when he/she takes a recommended medication.

**Elements of Consent**

In those treatment procedures which are not based upon scientifically-significant observations, it is particularly essential that full informed consent be obtained from the patient. The basic elements of this informed consent should be:[32]

1) An explanation of the procedures to be followed, including an identification of those which are not based upon scientifically-valid observations or statistically-significant results and thus are experimental;[33]
2) A description of the attendant discomforts and risks;[34]
3) A description of the benefits which may be expected;
4) A disclosure of appropriate and available alternative procedures that would be advantageous for the patient;
5) An offer to answer any inquiries concerning the procedures;
6) An instruction to the patient that he is free to withdraw his consent and discontinue the treatment at any time;
7) The physician has the continuing responsibility to inform the patient about any significant new information arising from other sources which might affect the patient's choice to continue the treatment;
8) In cases where a patient is mentally incompetent or too young to comprehend, informed consent must be obtained from one who is legally authorised to consent on behalf of the proposed subject. However, where the subject is a child who has

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[31] Op cit, n. 27.

[32] Department of Health, Education and Welfare (DHEW), DHEW Publication No. (OS) 78-0014, *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research. The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research,* Appendix Volume II: 13-5 to 13-6. Retrieved December 10, 2017 from https://videocast.nih.gov/pdf/ohrp_appendix_belmont_report_vol_2.pdf

[33] The procedure to be followed can only be known where a prior proper diagnosis has been conducted by the doctor.

[34] Also known as, side-effects. See also op cit, n. 25.

reached the age of some discretion such as adolescence or if the patient is otherwise mentally competent: the physician should obtain the patient's consent in addition to that of the person legally authorised to consent on his behalf.

**Who may give Consent?**

The issue of "who can give consent?" is a complex one. This is because it goes to the root of a patient's capacity/competence regarding his/her "age" and "understanding", and the general rule is that a person that possesses the necessary legal capacity is permitted to give an informed consent.

A patient is capable to give informed consent if he/she has attained the stipulated legal age, that is, grown from a minor/child to an adult. According to Rule 19 of the Rules of Professional Conduct for Medical and Dental Practitioners 1995,[35] a person below the age of eighteen years (18) by Nigerian law is under age, that is, a minor, and such lacks the stipulated age of giving a valid consent to medical treatment.

However, age alone does not dictate whether a person has or lacks capacity/competence to consent, "understanding" is also very important, that is, having the mental ability to comprehend one's medical condition as explained by one's doctor and subsequently make rational decisions.

Generally, an adult who has a perfect understanding of his medical condition, the required treatment, benefits and risks attached to such, and alternative treatment has the ability to give his/her consent or reject same. In *Re C (Adult: Refusal of Treatment),*[36] C had been admitted to a secure hospital as a patient under Part III of the Mental Health Act 1983 because of his paranoid schizophrenia. He now sought an injunction to prevent the amputation of his gangrenous foot without his written consent. The patient's persecutory delusions might have prevented him from weighing the information relevant to having his leg amputated because of gangrene, which he was perfectly capable of understanding, but they did not. It was held that a person may have capacity to manage his affairs notwithstanding that he has schizophrenia, and did in this case. Furthermore, Thorpe J. said: "For the patient offered amputation to save life, there are three stages to the decision (1) to take in and retain treatment information, (2) to believe it and (3) to weigh that information, balancing risks and needs.' and 'the question to be decided is whether it has been established that C's capacity is so reduced by his chronic mental illness that he does not sufficiently understand the nature, purpose and effects of the

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35 Op. cit, n. 2.

36 [1994] 1 WLR 290.

proffered amputation". and "Although his general capacity is impaired by schizophrenia, it has not been established that he does not sufficiently understand the nature, purpose and effects of the treatment he refuses. Indeed, I am satisfied that he has understood and retained the relevant treatment information, that in his own way he believes it, and that in the same fashion he has arrived at a clear choice".

Therefore, where an adult patient's capacity is reduced by illness, but, he/she is able to understand the nature, purpose and effects of his/her proposed treatment, such patient can consent. However, where a patient lacks competence to consent to medical treatment, his/her surrogate can make such consent on his/her behalf. For instance, the parent or closest relative of a mentally-incapacitated or unconsciousness patient can give consent for him/her.[37] Also, where a treatment involves marital procedure like abortion, vasectomy, or some family-planning choices, the wishes of the spouse would be sought. Although the latter is not legally mandatory but practically required.

In the case of a minor/child, a parent or guardian acts as his/her surrogate from whom consent would be obtained. The case may be different, however, where the minor/child is matured, also known as matured minor[38] or adolescent.

**Limitations to the Doctrine of Informed Consent**

Limitations to the doctrine of informed consent do exist, and physicians do not have a duty to disclose every remote risk associated with a medical procedure.[39] For example, the physician does not need to disclose the chance that a spinal anaesthetic may be contaminated and may, therefore, cause neurologic damage if the chance of contamination is no longer considered a current risk. Nor do physicians have a duty to disclose risks considered common knowledge or already obvious to the patient, such as the risk of infection following a surgical operation.[40] However, physicians should note

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[37] *Canterbury v. Spence*, 464 F.2d 772. See also *Miller v. Rhode Island Hosp.*, 625 A.2d 778 (1993).

[38] A matured minor is a minor who understands his medical condition, the procedure in question, and whose medical procedure is not serious. Age in this context does not really matter as age is just a number. Sometimes, a poorly-educated adult who has the mental capacity of a child lacks consent while a young child of 12 years with mental and emotional stability to comprehend issues can give consent. The age of maturity has rapidly become irrelevant in consent situations.

[39] Hartman, K. M. and Liang, B. A. 1999. Exceptions to Informed Consent in Emergency Medicine. *Hospital Physician.* 53-59. Retrieved December 11, 2017 from www.turner-white.com/pdf/hp_mar99_emergmed.pdf

[40] Ibid. See also *Percle v. St. Paul Fire and Marine Insurance Co.* (1977) 349 So. 2d 1289; *Salis v. U.S* (1981) 522 F.Supp. 989; *Kissenger v. Lofgren* (1988) 836 F.2d 678; *Haberson v. Parke Davis, Inc.* (1984)

that "[r]isks of drug side-effects . . . are singled out for disclosure by some courts, even if the risk of side effect[41] is small". Fundamentally, the law only requires disclosure of risks defined as material, as judged by the seriousness or chance of occurrence.[42] In the case of *McKinney v. Nash,*[43] the court defined material information in the following terms:

> Material information is that which the physician knows or should know would be regarded as significant by a reasonable person in the patient's position when deciding to accept or reject the recommended medical procedure. To be material, a fact must also be one which is not commonly appreciated. If the physician knows or should know of a patient's unique concerns or lack of familiarity with medical procedures, this may expand the scope of required disclosure.

Similarly, in *Harnish v. Children's Hospital Medical Center,*[44] the court ruled that "a physician owes to his patient the duty to disclose in a reasonable manner all significant medical information that he possess or should reasonably possess that is material to an intelligent decision by the patient whether or not to undergo that procedure.' It is important for the physician to understand that for proper decision making, 'not all medical facts are material ones and not all material facts are medical ones".[45]

Furthermore, a doctor is limited in his patient's treatment by the scope of what such patient has consented to,[46] that is, the extent of the therapeutic/surgical procedure must be within the range of the consent granted by a patient, and where a doctor exceeds such scope, he would be held liable at the suit of the patient. For example, in *Mohr v. Williams,*[47] the plaintiff brought suit against defendant for assault and battery. The

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746 F.2d 517; *Crain v. Allison* (1982) 443 A.2d 558. See also Liang, B.A. 1996. What needs to be Said? Informed Consent in the Context of Spinal Anesthesia. *J. Clin Anesth.* 8: 525–527.

41 *Younts v. St. Francis Hosp. & School of Nursing, Inc.* (1970) 205 Kan. 292, 469 P.2d 330. See also *Cunningham v. Charles Pfizer & Co.* (1974) 532 P.2d 1377.

42 *Percle v. St. Paul Fire and Marine Insurance Co.* (1977) 349 So. 2d 1289; *Salis v. U.S* (1981) 522 F.Supp. 989; *Haberson v. Parke Davis, Inc.* (1984) 746 F.2d 517; *Crain v. Allison* (1982) 443 A.2d 558; *Contreras v. St. Luke's Hosp.* (1978) 144 Cal.Rptr. 647.

43 (1981) 174 Cal.Rptr. 642.

44 (1982) 439 N.E.2d 240.

45 Op. cit, n. 10: 412.

46 Op. cit, n. 39.

47 104 N.W. 12 (Minn. 1905).

defendant, an excellent physician and ear specialist, examined the plaintiff's right and left ears. The defendant informed plaintiff of the result of his examination and advised her to have an operation on her right ear. The plaintiff was not informed that her left ear was in any way diseased. The plaintiff agreed to undergo surgery on her right ear. While unconscious, the defendant found the plaintiff's left ear to be in a more serious condition than her right ear. The defendant also found the right ear to be less serious than expected. The defendant concluded that the right ear should not be operated upon and that, instead, plaintiff's left ear should be operated upon. The plaintiff was unconscious, was not informed, and did not consent to her left ear being operated upon. The operation on plaintiff's left ear was in every way successfully and skilfully performed. However, plaintiff claimed that defendant's operation on her left ear greatly impaired her hearing. Plaintiff brought suit against defendant for assault and battery to recover damages for the hearing impairment in her left ear. It was held that if an operation is performed without plaintiff's consent, and the circumstances were not such as to justify its performance without consent, then the operation is wrongful and thus unlawful. The defendant was held liable.

**Exceptions to the Doctrine of Informed Consent**

The doctrine of informed consent is not a straight-jacket rule but subject to some exemptions. The first one is cases of public health emergency actions such as quarantine or vaccination as often required by law.[48] In such situations, the consent of the patient will be dispensed with and his/her medical condition would be disclosed in the interest of the public in order to protect the public from danger or medical harm, and to curtail further spread of the disease, in case of a disease outbreak. With respect of this, the Nigerian medical team has been, and is, proactive in protecting the whole country. Two major instances that can easily be related to are those of Ebola virus in 2014 and Monkey Pox outbreak in 2017. Ebola virus was brought into Lagos, Nigeria, by Mr. Patrick Sawyer, a Liberian-American financial consultant who denied exposure to Ebola. He was treated for presumed malaria after suffering from a fever, vomiting and diarrhoea. Eventually, after some days, medical tests revealed he actually had Ebola. His physician, Dr (Mrs) Adadevoh did the needful. She called officials of the Federal Ministry of Health and National Centre for Disease Control to inform them in a bid to protect the public from danger. She also went online, downloaded information on Ebola



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[48] Berg, J.W. 2012. All for One and One for All: Informed Consent and Public Health. *Houston Law Review.* 50:1: 1-41.

and printed copies, which were distributed to the nurses, doctors and ward maids. Protective gear, gloves, shoe covers and facemasks were provided for the staff while a wooden barricade was placed at the entrance of the door to keep visitors and unauthorised personnel away from the patient.[49] The disclosure of the patient's information, without respect to his right to consent by Dr (Mrs) Adadevoh, coupled with other measures helped in the successful eradication of ebola in Nigeria.

The second and commonest exemption is that of medical emergency in which delay in seeking a patient's or his/her surrogate's consent might be harmful.[50] An almost universal exception to the doctrine of informed consent applies when the patient is unconscious and the probability of harm because of failure to treat is great and surpasses any threatened harm from the treatment itself.[51] The premise of this exception is that, when the patient is unconscious and in immediate need of emergency medical attention, the duties of disclosure imposed by the doctrine of informed consent are excused because irreparable harm and even death may result from the physician's hesitation to provide treatment.[52] In *Barnett v. Bachrach,*[53] a surgeon operated on a patient for a presumed ectopic pregnancy, following obtaining consent for such surgery. During the surgery, the surgeon noted acute appendicitis, and removed the appendix, based upon the assumption that a reasonable person would agree to this course of action, although the patient was unable to provide consent at the time she was under general anaesthesia. Following the patient's recovery, the patient refused to pay for the surgical services provided because informed consent was not first obtained and thus the procedure was unauthorised. The court found that the surgeon had acted properly, in accordance with his professional judgment.

The court understood that, to deny the existence of an emergency situation and insist on traditional informed consent, would "make every surgeon litigation-conscious instead of duty-conscious as he stands, scalpel in hand, over his unconscious patient".

It is essential to note that, for the unconscious-patient exception to apply, the relevant emergency situation must require immediate medical attention with insufficient time to

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[49] *The Cable.* November 30, 2017. Retrieved December 14, 2017 from https://www.thecable.ng/how-i-survived-ebola-2 See also *The Guardian* August 4, 2014. Retrieved December 14, 2017 from https://www.theguardian.com/world/2014/aug/04/doctor-nigeria-ebola-victim-lagos

[50] *Canterbury v. Spence,* (1972) 93 S. Ct. 560.

[51] *Ibid.*

[52] Op cit, n. 39: 54.

[53] (1943) 34 A.2d 626.

fully inform the patient or seek consent from another authorized person.[54] In *Tabor v. Scobee*[55], the court found that a violation of informed consent had occurred. During the course of an authorised appendectomy on a female patient, the surgeon became aware of the patient's infected fallopian tubes and decided to remove the tubes at that point in the best interest of the patient. The court held that the surgical procedure did not fall within the exception to informed consent in an emergency situation. Despite the surgeon's determination that a long-term delay (i.e., 6 months) in the removal of the patient's fallopian tubes could result in serious harm or death, the patient's medical condition did not constitute an emergency because the patient would have had time to make an informed decision as to when she wished the procedure to be performed.

Furthermore, doctors are normally in a dilemma when faced with emergency situations involving an unconscious patient requiring blood transfusion. The dilemma is real where the unconscious patient had earlier shown or his/her family members indicate that the patient is opposed to blood transfusions for religious reasons and that the family will not provide the necessary consent. For instance, in *Malette v. Shulman,*[56] In June 1979, Georgette Malette, a Jehovah's Witness, was seriously injured in an automobile accident and was rushed to the hospital. Dr Shulman, the defendant, determined that Malette's profuse bleeding mandated blood transfusions to preserve her life. He administered such treatment despite knowing, from a card she carried, that Malette had expressly requested that no blood transfusions be given her under any circumstances. Malette sued, alleging that the blood transfusions constituted negligence, assault and battery, and religious discrimination. The trial court held that the Jehovah's Witness card validly restricted Shulman's right to treat Malette. The Supreme Court of Ontario affirmed the trial court's judgment, concluding that Malette had informed the physician of her objection to blood transfusions in the only way she could. Malette's instructions stood.

Also, where an unconscious patient's family member refuses to grant consent of blood transfusions for religious reasons, majority of American courts have assessed the issue using the standard of the compelling state interest in the preservation of life, which outweighs the patient's religious tenets as expressed by his or her family members. Thus, in *Cruzan v. Director, Missouri Department of Health,*[57] the plaintiff, Nancy Cruzan was involved in an automobile accident which left her in a 'persistent vegetative

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54 Op cit, n. 34: 54-55.

55 (1951) 254 S.W.2d 474.

56 (1990) 47 DLR 18.

57 (1990) 497 US 261.

state.' She was sustained for several weeks by artificial feedings through an implanted gastronomy tube. When Cruzan's parents attempted to terminate the life-support system, state hospital officials refused to do so without court approval. The Missouri Supreme Court ruled in favour of the state's policy over Cruzan's right to refuse treatment. However, the Nigerian court has reacted by respecting and protecting the wishes of a patient, even where he/she has refused blood transfusion. In *the Medical and Dental Practitioners Disciplinary Tribunal v. Okonkwo*[58] discussed above, where both the patient and her husband refused to give consent to blood transfusion due to their religious beliefs of which the respondent doctor, a fellow Jehovah Witness member, respected their wishes; the trial court found the doctor guilty of breaching the Code of Medical Ethics, but the Supreme Court overruled the decision and held that the Tribunal failed to give adequate regard to the conduct of the respondent in the light of accepted principles of law enjoining medical practitioners to respect a competent adult patient's refusal of medical treatment, including blood transfusion, for religious reasons.

Third an incompetent person, such as a minor or a person with diminished capacity (a mentally-unstable or alcoholic-induced), cannot give consent to his/her treatment except his/her parents or guardian does so on his/her behalf. As a general rule, a minor lacks the capacity to consent to treatment. Since consent, by definition, is given for an intervention for oneself, parents cannot provide informed consent on behalf of their children. Instead, they can provide informed permission for treatment. For older children and adolescents, assent should always be sought in addition to the authorisation of legal surrogates. Adolescents and mature minors are legally and ethically authorised to provide informed consent if they are emancipated, and in some jurisdictions, they may provide consent for matters regarding sexual and reproductive health, mental health, and substance abuse.[59]

For younger minors, an uncertainty arises in Nigeria where a parent refuses a necessary blood transfusion to preserve the life of his/her minor child. This is because parents owe their children the duty to provide them with necessities in life, which include medical treatment. But what will be a Nigerian court's decision? In the UK, the court concluded in *Darren and Deborah Wyatt v. Portsmouth Hospital NHS Trust*[60] that, when making a decision in a child's best interests, the welfare of the child is paramount

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[58] [2001] WRN 1 (n. 11). See also *Natanson v. Kline* (1960) 186 Kan. 393; and *In Re Osborne* (1972) 294 A.2d 372.

[59] Bord, J. 2014. Informed Consent. *Ethics in Medicine: University of Washington School of Medicine.* Retrieved December 14, 2017 from

[60] [2005] EWCA Civ 1181.

and the quality of a child's life must be considered from the child's perspective and not the parents' or doctors'. The responsible clinician must undertake a balancing exercise weighing all relevant factors. One factor may be whether the child's life has, or will, become "intolerable" but this is only one factor to be put into the balance. There is, of course, a strong presumption in favour of prolonging life but this is not absolute and does not circumvent the need to consider the best interests test. Also, in the US case of *Prince v. Massachusetts,*[61] the court ruled that the state's interest in protecting children through the child labour laws overrides the parent's constitutional right to raise her children and the children's constitutional right to practise religion as they choose. The Supreme Court stated further:

> Parents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves.

However, the uncertainty on this issue will persist in Nigeria until the court makes a decision, or the law relating to this is established by the law-makers.

Contrariwise, a parent's consent may be dispensed with where a minor is in an emergency situation. In *Jackovach v. Yocom,*[62] a 17-year-old boy was severely injured when he jumped from a moving train and was caught and dragged 80 ft by an iron step protruding from behind the train car. The boy suffered a crushed elbow joint and a 2-to-3-in scalp laceration from which he was bleeding profusely. The boy was subsequently brought to the operating room and anesthetised so that the physicians could stop the bleeding from the scalp wound. While the boy was under anaesthesia, the physicians determined that the boy's arm needed to be amputated because of the immediate danger it posed to his life. After the arm was amputated, the boy and his parents brought suit against the physicians based on the theory that the procedure was performed without their informed consent. In holding for the defendant physicians, the court noted that the physicians were faced with the decision of bringing the patient out from under anaesthesia only to obtain consent from the patient and his parents for the amputation. Returning the patient to consciousness for this time would have subjected the patient to greater risk of shock because of a necessary second anaesthesia induction. The court

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61 (1944) 321 US 158.

62 (1931) 237 N.W. 444.

held that, in the face of this life-threatening emergency, the physicians acted with skilled judgment by deciding to amputate the arm.

Doctors should be very careful so as not to be found liable whenever they want to dispense with parent's informed consent, especially in immediate, but not emergency, cases. In *Rogers v. Sells,*[63] the court found that a defendant physician was liable for not obtaining parental informed consent before amputating a 14-year-old boy's foot following a car accident. This is because the state of the boy's leg was not an emergency with the danger of immediate harm.

On the other hand, where a matured minor/adolescent is involved, his/her consent would be required where it is believed by the doctor that the matured minor understands the information about his/her medical condition and treatment. For instance, in *Younts v. St. Francis Hospital,*[64] a 17-year-old minor was at the hospital visiting her mother, who had undergone major surgery and was in a semi-conscious state. During her visit, the minor severed a portion of her finger in the hinge of a closing door. The minor patient was taken to the emergency room at which time she consented to surgical treatment, including a pinch graft taken from her forearm. The procedure was successfully completed. However, the patient's mother brought suit against the hospital based on a lack of informed consent for performing the surgical procedure. The patient's mother indicated that, if she had been consulted for the purposes of informed consent, she would not have given her consent and, instead, would have first sought the opinion of her family physician. However, the court noted that if the treating physician waited for the patient's mother to completely regain consciousness following surgery to obtain consent for the daughter's treatment, the patient would have needlessly endured a painful injury. Furthermore, the patient's father lived 200 miles away (as the patient's parents were divorced) and his address was unknown, so it was not possible to obtain his consent for the patient's treatment. Finally, the court used a contract standard to assess whether the patient could provide informed consent, despite being a minor. In this case, the court concluded that, on the basis of the patient's age and her apparent ability to comprehend the intricacies of the situation, the patient was mature enough to understand the nature and consequences of the procedure (i.e., similar to entering into a contract) and thus was mature enough to "knowingly consent to the beneficial surgical procedure made necessary by the accident".

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[63] (1936) 178 Okla. 103.

[64] (1970) 469 P.2d 330.

A similar position was held by the Nigerian court in the case of *Dr Rom Okekearu v. Danjuma Tanko*[65] in which the plaintiff had his left middle finger injured following a freak accident. The finger was amputated at the defendant's hospital. No effort was made at the instance of the defendant to obtain directly the consent of the plaintiff who was 14 years of age at the material time before the amputation. Rather, the defendant sought to rely on consent he purportedly obtained from the plaintiff's aunt couched in these words, "carry on with whatsoever treatment necessary". Subsequently, the plaintiff became dissatisfied with the resultant incapacitation in handling objects, and he sued the defendant, claiming damages for battery resulting from the amputation. The defendant denied negligence and pleaded that, in any case, he had consent from the plaintiff's aunt. The Supreme Court found that the respondent was 14 years of age by the time of the amputation of his finger and was rational enough to have given a valid consent. The Court held that effort should have been made to obtain his consent even before seeking the consent of the aunt which did not amount to a valid consent.

Further, if a minor is in need of a life-saving blood transfusion, the majority of courts are much less hesitant to intervene because of the compelling state interest in preserving the life of a child. Even when both the patient and the patient's parents have adamantly expressed their refusal to consent to a life-saving blood transfusion (generally because of religious beliefs), upon petition to the court, the state is likely to intervene to preserve the life of the minor.[66]

Generally, a mentally-unstable patient, who lacks the will to understand, cannot give consent to treatment except his/her surrogate does so on his/her behalf. However, where the patient can comprehend the details of his medical situation, he/she will be allowed to give consent for his/her treatment as held in the case of *Re C (Adult: Refusal of Treatment)*.[67] Also, the courts have also indicated that alcohol intoxication may render a patient incapable of granting informed consent, and that the standard of medical competency should be used when making such a determination. In *Miller v. Rhode Island Hospital,*[68] an intoxicated patient (with a blood alcohol level of 0.233) was brought to the hospital after he was injured in a motor vehicle collision. In the course of evaluating the patient for a traumatic injury, the physicians advised the patient that a diagnostic peritoneal lavage was going to be performed. The patient stated that he did

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65 (2002) 15 NWLR (Pt 791) 657.

66 See *Novak v. Cobb County-Kennestone Hosp. Authority*, (1994) 849 F. Supp. 1559, aff'd, (1996) 74 F.3d 1173.

67 [1994] 1 WLR 290 (n. 31).

68 (1993) 625 A.2d 778.

not want that procedure, but the physicians thought that the patient was sufficiently impaired by his alcohol intoxication such that the patient lacked the capacity to understand the purpose of the procedure. After resisting the efforts of the physicians, the patient was restrained, and a diagnostic peritoneal lavage was performed. The patient later sued for battery. Finding that intoxication did not affect the plaintiff's legal competency, the trial court found in favour of the plaintiff, but the defendants appealed the decision. The Rhode Island court found that intoxication could very well affect the plaintiff's mental capacity to make decisions and that the issue was one that should be decided by a jury. The Supreme Court of Rhode Island found in favour of the defendants and remanded the case back to the district court for a new trial, wherein the issue of the plaintiff's capacity to make medical decisions in light of his intoxication would be decided by a jury.

The fourth exception enables a doctor to withhold all or part of the informed consent discussion if it is reasonably believed that disclosure to the patient would be harmful or pose a serious threat to the patient's wellbeing. Thus, in the case of *Canterbury v. Spence,*[69] the court held that:

> It is recognized that patients occasionally become so ill or emotionally distraught on disclosure as to foreclose a rational decision, or complicate or hinder the treatment, or perhaps even pose psychological damage to the patient. Where that is so, the cases have generally held that the physician is armed with the privilege to keep the information from the patient, and we think it clear that portents of that type may justify the physician in action he deems medically warranted. The critical inquiry is whether the physician responded to a sound medical judgment that communication of the risk information would present a threat to the patient's wellbeing.

However, this is a vague concept that presents a slippery slope and should be avoided by a doctor whenever possible as it may result in a lawsuit.

Finally, a patient can expressly waive his consent by releasing his doctor from the obligation of informed consent. The patient may say, "I trust you and I don't need to have you explain it to me". This waiver is a dicey one because it is an actual consent and must also be informed, and a doctor should not be tempted to allow a patient to waive the process for two reasons. Firstly, it is tenuous to defend waiver in court due to its

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[69] (1972) US LEXIS 348.

uncertain principle, and secondly, it deprives a doctor of the opportunity to educate his patient about the risks and benefits of the treatment.

**The Symbiotic Relationship between a Patient's Autonomy/Freedom and Informed Consent**

A doctor who disregards a patient's right to self-determination and embarks on a treatment for which consent is not given by the patient exposes himself to the civil wrong of trespass to person and may in fact face criminal charge for assault.[70] Thus, any doctor who examines or treat a patient against his will would be liable for civil or criminal assault. The reason for this is that every patient is vested with the right of self-autonomy. It is the patient's informed consent to treatment that constitutes authority for any treatment to be administered to him.[71]

However, to arrive at informed consent, it is necessary to provide the patient with adequate information about all aspects of his/her choices and this information should be sufficient and accurate.[72] Adequate information includes explanation and details on the benefits and risks of the proposed and alternative treatments. They also should include the option and consequences of no treatment.[73] Health-care professionals and patients should actively participate in the informative process in order to execute informed consent.[74] The provided information should be in a way which does not increase anxiety or decrease confidence.[75] The presentation and explanation of the information should be adjusted to suit the patient's language, level of maturity and competence. The patient should be able to weigh the relevant factors in order to conclude to a balance view and finally make a decision.[76] The information should be provided far in advance in order for the patient to have sufficient time to give it due consideration and arrive at a decision voluntarily.[77]

Therefore, there is a symbiotic relationship between autonomy and informed consent. The symbiotic relationship between both rights exists in the sense that the

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[70] Emiri, F.S. 2012. *Medical Law and Ethics in Nigeria.* Lagos: Malthouse Press Ltd.
[71] Ibid.
[72] Haddad A. and Vernarec E. 2001. Ethics in Action. *RN.* 64.5: 2526.
[73] Op cit, n. 5.
[74] Arnold T. 2002. The Informed Consent Doctrine. *New Jersey Medicine.* 99.4: 24-31.
[75] Kerridge I. and Lowe M. 1997. Informed Consent and Shared Decision Making. *Student BMJ.* 5: 275-277.
[76] Nidhi S. 1997. Question of Consent. *Student BMJ.* 5: 277-279.
[77] Op cit, n. 5; and Olsen-Chavarriaga D. 2000. Informed Consent Do You Know Your Role? *Nursing.* 30.5: 60-62.

ethical imperative of giving patients comprehensive information allows the patients to make independence choices. During this process, explicit communication of information is provided that would relevant to help the patient decide whether or not to have a particular treatment or procedure.[78] As far as patients have the right to obtain information about their health care, they have also the right to accept or reject any suggested options.[79] Hence, it is only when a patient has been fully informed that he/she can enjoy his/her right of autonomy or self-determination and choose whether to undertake the proposed treatment (give consent), try an alternative treatment or out rightly refuse all treatments (refusal of consent). Therefore, the nexus between autonomy and informed consent is that informed consent is an essential safeguard of patient autonomy. Without autonomy, informed consent is in vain, and without informed consent, autonomy is a toothless bulldog.

**Conclusion and Recommendations**

The aim of this paper has been an examination of the twain concepts of autonomy and informed consent, and the symbiotic relationship between them. Although both concepts are analogous, they are two different rights which a patient is entitled to enjoy. However, the enjoyment of one leads to the other, and where one is denied, the other is also deprived. Accordingly, while autonomy relates to the right of self-determination, informed consent refers to the ability to be informed about one's medical condition, the accompanying treatment, its risks and benefits, and the available alternatives. It is only when these elements are known that a patient can make an autonomous decision. Hence, the purpose of informed consent is for a doctor to respect his patient's autonomy and further enable him to make important decisions regarding his medical care.

However, notwithstanding the overall importance of the rights of autonomy and informed consent, and the synergy between the two, both or one of the two rights are normally being denied patients in Nigeria, thus, this paper acclaims some recommendations.

The major recommendation is the sensitisation of both patients and doctors on the need for the recognition and enjoyment of both concepts. Due to poverty, illiteracy, level of education, and perception of Nigerian patients as reflected in the statistics in the introduction, several people do not know their rights as patients at all. No wonder some

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[78] Op cit, n. 5.

[79] Levinsky N.G. 1996. Social, Institutional, and Economic Barriers to the Exercise of Patients' Rights. *The New England Journal of Medicine.* 22: 532- 534.

physicians infringe on their rights and patients keep quiet/do not fight back. Hence, government should conduct awareness programmes or trainings to sensitise all her citizens about their rights to adequate medical services as Nigerian patients. On the contrary, Nigerian medical schools should also restructure their teaching of medical ethics to improve the knowledge and practices of doctors while doctors, who are already practising, should also undergo training on improved medical ethics, especially on patients' rights, and the significance of the symbiotic relationship between a patients' autonomy and informed consent, in order to improve citizens' confidence in medicine.

Furthermore, it is suggested that the Nigerian government should produce a guidance or working paper on autonomy and informed consent, and how they can be entrenched. The guidance should also provide for who a matured minor is, that is, the age range. Further, it should recommend a law on whether a state's interest in protecting a child will override that of a parent in refusing a necessary blood transfusion based on the parent's religion or belief. These laws and guidance will erode all forms of confusion on the age of a minor, matured minor, informed consent of a minor, his/her surrogate's (e.g. parent's) responsibilities.

Finally, on the issue of enforcement, the forms of discipline against negligent/unruly physicians should be taken seriously. It is either such doctors are warned, suspended for a maximum period of six months or their names be struck off the Register. Also, patients should be encouraged to institute both civil and criminal cases against such physicians, and the Court should exercise due justice to serve as deterrence to other physicians.