AUTONOMY *VERSUS* PATERNALISM IN MEDICAL PRACTICE IN NIGERIA: A SOCIO-LEGAL DISCOURSE

Abstract

In the medical sphere, medical professionals and patients often have to contend with issues relating to the proper course of action to take at specific points in time as dictated by the imperatives of legal rights and duties. 'Autonomy' refers to a person's right to freedom from undue interference into his/her private space hence, right to self-determination. Medically, autonomy or respect for autonomy is about allowing patients to decide or be part of the decision-making on their health. On the other hand, 'paternalism' is the practice by medical professionals that one's claim for the respect of his/her autonomy rights must not supersede what is seen or perceived as good for him/her in a given circumstance. Medically, paternalism refers to an action performed by a medical practitioner with the intent of promoting another's good even though such act may be against his/her will or done without his/her consent. To uphold a patient's right to autonomy in some cases may negate the doctor's duty of beneficence and non-maleficence leading to paternalistic medical practice. To this end, the study considered the issues surrounding autonomy and paternalism as a potential negation of patient's best interests, medical professional's discretion and the society's common interest. The study found that respect for autonomy rights of patients stands at the core of every doctor-patient relationship and thus, supreme and quintessential. The study further found that conceptualizing autonomy within the context of the individualism of western societies may not be fit for purpose in an African context like Nigeria.

Keywords: Autonomy, paternalism, medical practice, beneficence, non-maleficence.

1. Introduction

Medical service is one sphere in which crucial questions of rights and duties arise from time to time.[1] Stated differently, it is one area where parties – medical experts and their clients – often have to contend with issues relating to the proper course of action to take at specific points in time as dictated by the imperatives of legal rights and duties. Consequently, choices made in such instances by either of the parties could have serious legal implications.[2] One of such instances which, at times, poses a difficult challenge of choice to health care professionals is where it comes to the observance of a patient's right to autonomy or making decision for patients who lack decision making capacity. Typically, a patient may lack decision-making capacity by reason of physical or mental incapacity or by reason of age. Such persons include those who are in unconscious state, mentally ill persons and minors.[3] Therefore, the fate of such persons inevitably lies in the hands of other persons who now have choices to make, taking into consideration the peculiar circumstances of the given case. Cases that could give rise to the need for such decision making on behalf of a patient include when there is need to apply a specific type of treatment (such as surgical procedure or blood transfusion) and when there is need to discontinue treatment (such as withdrawal of life support). Such treatments are usually of very sensitive nature given their grave implication for the wellbeing and even the life of the patient.[4] For instance, some persons, for reasons of religious belief, may find certain medical procedures objectionable; a recurring example is objection to blood transfusion by adherents of Jehovah's Witnesses. There is also the example of persons who may object to an abortion procedure intended to save life. Again, surgical procedures are typically invasive and certain drugs come with some serious risks to the patient that it may be inappropriate and even risky to assume that a patient would naturally have no objection to them. Hence, decision making becomes a sensitive issue here. In *Chester v. Afshar*,[5] Lord Steyn posits that:

> ... 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

***By Chinemelum Nelson ARINZE-UMOBI,** Lecturer, Department of Public and Private Law, Faculty of Law, Nnamdi Azikiwe University, Awka, Anambra State, Nigeria. Tel: +2348060913355. Email: cn.arinze-umobi@unizik.edu.ngnelsonzelo@gmail.com, and

* **Godwin N OKEKE,** Professor of Law, Department of International Law and Jurisprudence, Faculty of Law, Nnamdi Azikiwe University, Awka, Anambra State, Nigeria. Tel: +2348033127505. Email: okekegodwin_40@yahoo.co.uk

[1]C Cameron& E Gumbel, *Clinical Negligence: A Practitioner's Handbook*. (Oxford University Press 2007), p.38.
[2]*Ibid.*,p.38.
[3]C P Selinger,'The Right to Consent: Is it Absolute?' [2009] (2) (4) *British Journal of Medical Practice*; p. 50.
[4]*Ibid.*,p. 50.
[5][2004] UKHL 41, para 18.

> 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.[6]

Treatment without proper consent could give rise to civil liabilities. For instance, a surgical procedure performed without the patient's due consent could amount to the tort of battery.[7] However, when the patient is incapable, a number of difficult questions arise as follows: which decision is the most appropriate to be made? Who is the most appropriate to make the decision? Is it right in the circumstance for anybody to assume the responsibility of decision-making on behalf of the patient in the first place? This last consideration is very crucial given the possibility of erroneous judgment in presuming a patient incapable of decision-making and in presuming oneself the right person to make the decision,[8] assuming the incapacity is genuinely present in the first place.

The basis of the problem encountered in making decision for those who lack the capacity in clinical setting lies in the need to preserve a patient's right to personal autonomy while at the same time ensuring that his/her best interest is served by the choices made regarding his/her health situation by medical experts, relatives and other concerned interests.[9] To understand the intricacy of this situation more clearly, the four major elements that are at play need to be specified.

i. The first element is the patient's 'best interest'; what decision and action should be taken to ensure that the patient's wellbeing is maximally served?
ii. The second is the patient's right to personal autonomy: does the action to be taken derogate from the patient's right to non-interference in his/her individual personal space?
iii. The third is the medical expert's professional discretion to offer his/her intervention in line with his best professional judgment and applicable industry standards.[10]
iv. And the fourth is the interest of third parties – the patient's relatives, the community and others likely to be affected by whatever course of action followed in the circumstance.

There now stands a possible contradiction between the patient's right to personal autonomy and whatever decision taken on his/her behalf and when this autonomy can be legitimately dispensed with. Where it is satisfied that the patient genuinely lacks capacity, there comes a possible contradiction between the decision made and the patient's best interest. In other words, does the decision taken on his/her behalf represent his/her best interest? Then if the patient's best interest, whatever it may be, is to be realised, there again comes a potential contradiction between it and the professional discretion and integrity of the medical expert as well as the interest of third parties either relatives or the public.

The foregoing basically represents the problem associated with making decision for patients who lack the capacity in a clinical setting. Such decision making practically places the actors in a difficult legal terrain where they are obliged to negotiate through tricky and intricately connected questions of rights and duties.[11] In this instance, it may be easy for one to default while trying to reconcile multiple interests that may at times seem contradictory and even irreconcilable.

In view of the foregoing, decision-making for those lacking capacity in the clinical scenario has become an important legal issue in many countries. In countries with a vibrant culture of clinical treatment-related litigations, it

[6] See also the earlier case of *Schloendorff v. Society of New York Hospital* [1914] 211 NY 125, 126.
[7] R Mulheron, 'Trumping Bolam: A Critical Legal Analysis of Bolitho's 'Gloss'' [2010] (69)*The Cambridge Law Journal;* p. 609.
[8]C P Selinger, 'The Right to Consent: Is it Absolute?' [2009] (2) (4) *British Journal of Medical Practice*; p. 50.
[9].O Aniaka,'Patients Right and the Socio-Cultural Challenges to Informed Consent in Nigeria' <file:///C:/Users/User/Downloads/Patient%20Right%20and%20the%20Socio-Cultural%20Challenges%20to%20Informed%20Consent%20in%20Nigeria.pdf> accessed 6 January2018.
[10] The *Code of Medical Ethics in Nigeria* provides that medical practitioners have 'absolute discretion and authority, free from unnecessary non-medical interference' in determining how to carry on with their service delivery (Paragraph 8[H]).
[11]C P Selinger, *op cit.*p. 50.

has yielded many judicial decisions[12] which, alongside legislative enactments,[13] have led to emergence of a reasonably dynamic legal framework. However, in Nigeria, the situation appears different as the law relating to decision making in clinical setting is yet to experience such development.[14]While the culture of clinical litigations is yet to become strong in the country,[15] Nigeria only relatively recently passed the National Health Act with provisions relating to clinical consent.[16] This implies that the Nigerian legal system, as far as clinical consent is concerned, is still relatively young. But before the National Health Act was enacted, the Nigerian legal system has accommodated statutory provisions related to right to privacy, freedom of religion and conscience, right to personal dignity, negligence, assault and battery – which are all in one way or the other relevant to clinical decision making. Nigeria is also signatory to international instruments recognising such relevant rights.[17] Nevertheless, experiences of other nations, such as the United Kingdom, Nigeria's erstwhile colonial masters, show that such statutory provisions alone may not be enough; judicial interpretations have proved crucially useful in improving their functionality in the light of the practical dynamism of everyday clinical experience.[18]Besides, none of the domestic legislations contain any provisions specifically and elaborately addressing the principles and procedures for deciding for those who lack capacity in clinical setting. Even the Code of Medical Ethics in Nigeria,[19]the statute-based principal regulatory instrument for medical and dental practitioners, while containing provisions on the imperative of patient's consent,[20] is silent on how such consent could be obtained for persons who cannot personally decide.

Consequently, one may wonder the much Nigeria's statutory provisions could go in addressing all the intricacies of deciding for those that are incapable of making decision(s) in clinical circumstances. It is against this background that this research sets out to study the Nigerian legal system with a view to assessing its strengths and weaknesses vis-a-vis the question of patient's right to autonomy, best interest, paternalistic medical practice and decision-making in the context of incapacity to decide. The issues are discussed from the perspectives of how the right to autonomy tends to negate the patient's best interest, the medical professional's discretion and the common interest of society. As a result, the research brings to the fore the problems surrounding the right to autonomy and paternalistic medical practice in relation to the best interests of a patient, the application of the medical professional's discretion and the society's common interest.

2. Autonomy and Paternalism

Autonomy or Respect for Autonomy (RFA) stands at the core of the principles of medical ethics namely autonomy, non-maleficence, beneficence and justice. Autonomy connotes an individual's freedom to exercise his/her personal choice irrespective of any other choice made by any other person. Patient autonomy is a fundamental principle of medical ethics, hence, the ability to recognize and foster it, and its various dimensions, is widely considered an

[12] *BLocal Authority v RM [2010] EWHC 3802* and *Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112* are some of the landmark cases decided in United Kingdom and which have been of defining influence on the legal framework for deciding for those who lack capacity.

[13] In the United Kingdom, the *Mental Capacity Act, 2005* and the *Children Act 2004* are some of the legislations relevant to decision making for those lacking capacity.

[14]See Rule 19 of the Code of Medical Ethics in Nigeria which provides for informed consent and how consent would be given in a situation where a patient lacks capacity.

[15] A I Sulaiman, and I G Diggol, and I MHaruna, 'Knowledge, Attitude and Perception of Patients Towards Informed Consent in Obstetric Surgical Procedures at Aminu Kano Teaching Hospital' [2018] (l2) (1) *Nigerian Journal of Basic and Clinical Sciences*; p. 45.

[16]Ss. 23 & 48 for instance. See also Ikenga K.E. Oraegbunam 'Jurisprudence of Genetic Engineering in Nigeria: Prospects and Challenges for Human Dignity in the Light of the National Health Act 2014', *International Journal of Business and Law Research* 3(4): 9-25, Oct.-Dec., 2015. http://seahipaj.org/journals-ci/oct-dec 2015/IJBLR/abstract/IJBLR%206.html.

[17] For instance, African Charter on Human and Peoples' Rights (domesticated by CAP A9 LFN 2004) provides for personal dignity *(Article 5)* and freedom of religion and conscience *(Article 8).*

[18] See the UK cases *BLocal Authority v RM supra*and *Gillick v West Norfolk and Wisbech Area Health Authority (supra).*

[19]2004.

[20]Paras 19 & 38.

important clinical competence for physicians.[21] However, its conception in the medical and ethical literature, as well as its practical implementation, still raises ongoing challenges for the practice of medicine.[22] Beauchamp and Childress in their work 'Principles of Biomedical Ethics' posit that:

> … Ethically, appropriate conduct is determined by reference to four key principles which must be taken into account when reflecting on one's behaviour towards others. They are: (i) the principle of respect for individual autonomy (i.e. – individuals must be respected as independent moral agents with the 'right' to choose how to live their own lives); (ii) the principle of beneficence (i.e. – one should strive to do good where possible); (iii) the principle of non-maleficence (i.e. – one should avoid doing harm to others); and (iv) the principle of justice (i.e. – people should be treated fairly, although this does not necessarily equate with treating everyone equally).[23]

In 1948, the World Medical Association's (WMA) General Assembly in Geneva, adopted the *Hippocratic Oath Declaration* wherein the professional duties of physicians as well as the ethical principles of global medical profession were outlined in concise terms.[24] Several amendments have been made to this Declaration – the latest being the newly revised version adopted by the WMA General Assembly, Chicago, United States, on October 14, 2017, which includes several important changes and additions to the physician's pledge. It reads:

> AS A MEMBER OF THE MEDICAL PROFESSION:
> - I SOLEMNLY PLEDGE to dedicate my life to the service of humanity;
> - THE HEALTH AND WELL-BEING OF MY PATIENT will be my first consideration;
> - I WILL RESPECT the autonomy and dignity of my patient;
> - I WILL MAINTAIN the utmost respect for human life;
> - I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing, or any other factor to intervene between my duty and my patient;
> - I WILL RESPECT the secrets that are confided in me, even after the patient has died;
> - I WILL PRACTISE my profession with conscience and dignity and in accordance with good medical practice;
> - I WILL FOSTER the honour and noble traditions of the medical profession;
> - I WILL GIVE to my teachers, colleagues, and students the respect and gratitude that is their due;
> - I WILL SHARE my medical knowledge for the benefit of the patient and the advancement of healthcare;
> - I WILL ATTEND TO my own health, well-being, and abilities in order to provide care of the highest standard;
> - I WILL NOT USE my medical knowledge to violate human rights and civil liberties, even under threat;
> - I MAKE THESE PROMISES solemnly, freely, and upon my honour.[25]

The most notable difference between the Declaration of Geneva and other key ethical documents such as the WMA's *Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects of 1964*[26] and the *Declaration of Taipei on Ethical Considerations Regarding Health Databases and Biobanks of 2002*,[27] was determined to be the lack of overt recognition of patient autonomy, despite references to the physician's obligation

[21] Murgic *et al*, 'Paternalism and Autonomy: Views of Patients and Providers in a Transitional (Post-Communist) Country' [2015] (16:65), *BMC Medical Ethics*, p. 1.
[22] *Ibid.*,p. 1.
[23] G T Laurie, S H E Harmon & G Porter, *op. cit.*, p. 5.
[24] R W Parsa-Parsi, 'The Revised Declaration of Geneva: A Modern-Day Physician's Pledge' *JAMA*.2017; 318(20): Pp. 1971–1972. doi:10.1001/jama.2017.16230 accessed April 5, 2019, Available at https://jamanetwork.com/journals/jama/fullarticle/2658261.
[25] *Ibid.*
[26] World Medical Association Declaration of Helsinki: ethical principles for medical research involving human subjects. *JAMA*. 2013; 310 (20):2191-2194.
[27] World Medical Association Declaration of Taipei on Ethical Considerations Regarding Health Databases and Biobanks. https://www.wma.net/policies-post/wma-declaration-of-taipei-on-ethical-considerations-regarding-health-databases-and-biobanks/. Accessed April 5, 2019.

to exercise respect, beneficence, and medical confidentiality toward his or her patient(s).[28] To address this difference, the workgroup, informed by other WMA members, ethical advisors, and other experts, recommended adding the following clause: 'I WILL RESPECT the autonomy and dignity of my patient'. In addition, to highlight the importance of patient self-determination as one of the key cornerstones of medical ethics, the workgroup also recommended shifting all new and existing paragraphs that are focused on patients' rights to the beginning of the document, followed by clauses relating to other professional obligations. Expressing respect for patients' autonomy means acknowledging that patients who have decision-making capacity have the right to make decisions regarding their care, even when their decisions contradict their clinicians' recommendations.[29] Beauchamp and Childress remind us that autonomy requires both 'liberty (independence from controlling influences) and agency (capacity for intentional action)'[30] and that liberty is undermined by coercion, persuasion, and manipulation.[31]

Clearly, from the foregoing, a physician is charged by the *Physician's Pledge* to respect the autonomy and dignity of his or her patient. The implication of this is that a physician is ethically bound to adhere to and respect his or her patient's autonomy while treating such a patient. However, respect for a patient's autonomy might in turn negate or contradict the patient's best interests – which is central to the duties owed by the physician to his or her patient – non-maleficence (duty to avoid harm to others) and beneficence (duty to strive to do good where possible).

Autonomy or right to autonomy here is perhaps mislabeled in the medical context as a patient does not have the right to decide which medical treatment she or he will be given. A patient has no right to demand that she or he be given cosmetic surgery. A health care professional may refuse because she or he does not want to provide the treatment or because of rationing of health care resources means it is not available. What is really being claimed here is a right of 'bodily integrity': a right not to have something done to your body without your consent.[32] Autonomy implies a responsibility to accept the consequences of one's decision.[33] At the heart of autonomy is the right to decide how we wish to live our lives.[34] So, to respect autonomy is to accept a person who has a right to hold views, make choices, and take actions based on personal values and beliefs.[35] To override a person's wishes is to treat that person as a means to reach other people's ends and to fail to respect their humanity.[36] In other words, in the medical sphere, it must exist consequent to information being given that influenced a user to make such a decision.[37] This voluntariness accords with the principle that an autonomous user is generally self-governing.[38] So, to tell a user to act in a particular way or take a particular decision does not prevent a person from exercising autonomy in granting or refusing consent.[39] However, where a user takes a decision after having been told or commanded to act in a particular way or take a particular decision, such negates the principle of informed consent[40] as was aptly seen in the case of *Moore v Regents of the University of California.*[41]In this case, Moore, a patient at the time, had his spleen taken out from his body with the aim of treating leukaemia. Samples of blood, bone marrow and other tissues were subsequently extracted from his body. He was then told by the hospital to amend his admission form to read

[28]R W Parsa-Parsi, *op. cit.*
[29]T L Beauchamp, & J F Childress, *Principles of Biomedical Ethics*, (4[th]ed. New York, NY: Oxford University Press, 1994), p. 58.
[30]*Ibid.*,p. 58.
[31] M D Laura Sedig, 'What's the Role of Autonomy in Patient-and Family-Centered Care When Patients and Family Members Don't Agree?' *AMA Journal of Ethics* 2016; 18 (1), p. 13. Available online at <https://journalofethics.ama-assn.org/article/whats-role-autonomy-patient-and-family-centered-care-when-patients-and-family-members-dont-agree/2016-01> Accessed 3 September 2019.
[32]J Herring, *Medical Law and Ethics* (7[th] edn, Oxford University Press, 2018), p. 26.
[33]M N Njotini, 'Preserving the Integrity of Medical-Related Information – How 'Informed' is Consent?' *PER / PELJ* 2018 (21) – DOI, p. 5. Available at <http://dx.doi.org/10.17159/1727- 3781/2018/v21i0a3400> Accessed 16 August 2019.
[34] J Herring, *op. cit.*, p.25.
[35]*Ibid.*, Pp. 25-26.
[36]*Ibid.*, p. 26.
[37]*Ibid.*,p. 5. See also Castell case *supra.*
[38]*Ibid.*,p. 5.
[39]*Ibid.*,p. 5.
[40]*Ibid.*,p. 5.
[41]51 Cal 3d 120 [1990].

that he consented to research being undertaken using the parts removed from his body of which he duly did as commanded. It was established later that Moore's physician and his assistant had created the Mo-cell line using the samples taken from Moore. Thereafter, they patented the line and made profit in a sum estimated at 3 billion US Dollars. It could be asked if Moore had also given his informed consent to the creation of the Mo-cell line. Is it legally justified to extend the informed consent given for the removal of a spleen to then create a profitable business?[42]

Today, the importance attached to autonomy has grown in recent years. We no longer regard ourselves as subjects of a higher authority, but as individuals with rights.[43] To more explicitly invoke the standards of ethical and professional conduct expected of physicians by their patients and peers, the clause 'I WILL PRACTISE my profession with conscience and dignity' was augmented to include the wording 'and in accordance with good medical practice'.[44] However, the argument in support for respect for autonomy (RFA) is not without criticisms. To this end, Saad stated thus:

> Autonomy is now no longer a privilege (Rousseau) or a duty (Kant), but a right. And thus the moral vacuum bequeathed by the Enlightenment quenches ethical inquiry, for what purpose is there in discussing the content and nature of morality any further if autonomy is assumed to be the *summum bonum*?[45] The ethics of autonomy which we are left with is but the crumbs underneath the table of classical ethics. In the age of autonomy, the discipline of ethics has morphed into something radically individualistic and reductive, something unrecognisable.[46]

Medical paternalism on the other hand involves a situation where the physician acts for the benefit of his or her patient without the actual consent of the person on whose behalf he acts. This is so because, traditionally, the physician-patient relationship is fiduciary in nature as the physician would apply his or her professional expertise in his or her patient's best interests and benefits.[47]Broadly speaking, the concept of paternalism is an action performed with the intent of promoting another's good but occurring against the other's will or without the others' consent.[48] The concept of paternalism comes from the Latin Word *'Pater'* which literally means 'to act like a father or to treat another person like a child'.[49] It is to act for the good of another person without that person's consent as parents do for their children. Therefore, in medicine, paternalism refers to acts of authority by the physicians in directing care and distribution of resources to patients as a result of the knowledge-based value judgments, apprenticeship and experience that have been gathered over the years by the physician with the sole aim of providing medical care that will benefit patients and prevent harm.[50] Similarly, in the context of healthcare, paternalism constitutes any action, decision, rule or policy made by a physician or other care giver, without considering the patient's own beliefs and value systems and does not respect patient autonomy.[51] In the same vein, Beauchamp and Childress have further described paternalism as:

> The intentional overriding of one person's known preferences or actions by another person, where the person who overrides, justifies the action by the goal of benefiting or avoiding harm to the person whose preferences or actions are overridden.[52]

The effect of medical paternalism therefore, is that patients were often treated without adequate explanation of what was involved or significant facts about their illness were kept from them – for example, it was common not to pass

[42]M N Njotini, *op. cit.*, p. 5.
[43]*Ibid.*, p. 26.
[44]Parsa-Parsi R W, *op. cit.*, p. 1972.
[45]This is a Latin expression meaning 'the highest good', especially as the ultimate goal according to which values and priorities are established in an ethical system.
[46] T C Saad, 'The History of Autonomy in Medicine from Antiquity to Principlism' [2017] *Med Health Care and Philos*, p. 13.
[47] P F Omonzejele, 'Obligation of Non-Maleficence: Moral Dilemma in Physician-Patient Relationship' [2005] (4) Journal of Biomedical Sciences, p. 23.
[48] J A Ayodele, 'The Realities Surrounding the Applicability of Medical Paternalism in Nigeria' [2015] (14) *Global Journal of Social Sciences*, p. 56.
[49]*Ibid.*,p. 56.
[50]*Ibid.*,p. 56.
[51]*Ibid.*,p. 56.
[52]*Ibid.*,p. 56.

on information if it was thought that the knowledge would cause distress, and psychiatric patients could be subjected to treatments without any concern as to their views or preferences.[53] Essentially, the basis of medical paternalism principle consist of promoting and restoring the health of the patient; providing good care; preventing patients from their own errors in judgement; and assuming responsibility.[54]

Against the foregoing background, the writer will consider the issues surrounding autonomy and paternalism in the sub-headings below.

3.Autonomy as a Potential Negation of Patient's Best Interests

Firstly, what comes to mind when autonomy is mentioned is the fact that a patient has the right to determine what is to be done on his/her body. Put differently, a patient undergoing treatment has the right or is in control of such treatment since he calls the shot. This being the case therefore, it means that any decision or act of the medical practitioner without the informed consent of the patient first sought and obtained may amount to a tort or crime being committed against such a patient since no attention was paid to the observance of the patient's best interests.[55] The questions that therefore come to mind here are:

i. Is the right to autonomy absolute?
ii. Is the medical practitioner bound to follow every wish or dictate of a patient?
iii. Are there circumstances in which a medical practitioner can depart from the observance of a patient's right to autonomy?
iv. What is the nature of the doctor-patient relationship?
v. Should observance of patient's best interests not be placed at the fore in the doctor-patient relationship?
vi. Is it not possible that while protecting a patient's autonomy, he/she may suffer a far graver harm than he/she might have suffered through loss of autonomy?
vii. Is it in the best interest of the patient to allow him/her suffer death or permanent physical or mental damage in the course of protecting his/her autonomy?
viii. At what point may autonomy be placed above other personal interests of the patient?

One of the most difficult problems associated with autonomy is that potentially, it may stand in opposition to what is viewed as the patient's best interest. Patient's autonomy is supposed to advance the interest of the patient; however, it becomes paradoxical that the same autonomy may be seen as potentially injurious to the very interest of the patient. In *Re T (adult) (refusal of medical treatment),*[56]a pregnant woman was involved in a car accident and, after speaking with her mother, signed a form of refusal of blood transfusion. Following a caesarian section and the delivery of a stillborn baby, her condition deteriorated and a court order was obtained legalizing blood transfusion on the ground that it was manifestly in her best interests; the declaration was upheld by the Court of Appeal. The fundamental decision was to the effect that an adult patient who suffers from no mental incapacity has an absolute right to consent to medical treatment, to refuse it or to choose an alternative treatment[57] – 'it exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent'.[58] However, *Re T's* case is not to be confused with the quite exceptional case of *NHS Trust v T (adult patient: refusal of medical treatment)*[59]where transfusion was refused because the patient thought her own blood was contaminating the transfused blood.

The authority in *Re T (adult) (refusal of medical treatment),*[60] was shortly applied in the case of *Re C (adult: refusal of medical treatment).*[61]The case involved a 68-year old patient suffering from paranoid schizophrenia who had developed gangrene in a foot while serving a term of imprisonment in Broadmoor. On removal of the patient to a

[53] G T Laurie, S H E Harmon & G Porter, *op. cit.,* p. 9.
[54] J A Ayodele, *op. cit.,* p. 57.
[55]See *Chester v Afshar* [2004] UKHL 41, para 18.
[56][1992] 4 All ER 649; [1992] 9 BMLR 46, CA.
[57] The only possible qualification mentioned by Lord Donaldson – where the choice might lead to the death of a viable fetus – see discussion at para 4.44 et seq.
[58][1992] 4 All ER 649; [1992] 9 BMLR 46 at 50, per Lord Donaldson.
[59][2005] 1 All ER 387.
[60]*Supra.*
[61][1994] 1 All ER 819; [1993] 15 BMLR 77.

general hospital, a consultant prognosed that he had only 15 per cent chance of survival if the gangrenous limb was not amputated below the knee. The patient, however, refused the operation, saying that he preferred to die with two feet than to live with one. The hospital questioned C's capacity to exercise his autonomy in this way and an application for an injunction restraining the hospital from carrying out the operation without his express written consent was lodged with the court on C's behalf. Thorpe J held that C was entitled to refuse treatment even if this meant his death. Quoting with approval the dicta of Lord Donaldson in *Re T,*[62] he stated that:

> *...prima facie,* every adult has the right and capacity to accept or refuse medical treatment. He acknowledged that this might be rebutted by evidence of incapacity but this onus must be discharged by those seeking to override the patient's choice. When capacity is challenged, as in this case, its sufficiency is to be determined by the answer to the question: has the capacity of the patient been so reduced (by his chronic mental illness) that he did not sufficiently understand the nature, purpose, and effects of the proffered medical treatment? This depends on whether the patient has been able to comprehend and retain information, has believed it, and has weighed it in the balance with other considerations when making his or her choice.

Thorpe J further stated:

> Applying that test to my findings on the evidence, I am completely satisfied that the presumption that C has the right to self-determination has not been displaced. 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.[63]

Similarly, in *Re W (adult: refusal of medical treatment),*[64]a case involving a self-inflicted injury, Butler-Sloss P held that a psychopathic prisoner with mental capacity on *Re C* terms could refuse treatment even though it might lead to his death. However, in the case of *Trust A v H (an adult patient),*[65]the court granted the applicant Trust's declarations to allow them to perform a hysterectomy on a patient who had been detained under the *Section 3* of the *English Mental Health Act,*[66]and who suffered from schizophrenia and had delusional beliefs – although the court confirmed that no medical treatment could be given without the consent of an adult patient who was competent to make decisions, it was clear that in the instant case, the patient did not appreciate the seriousness of her condition and the sense of threat to life that it presented if unalleviated.

4. Autonomy as a Potential Negation of Medical Professional's Discretion

Another quintessential argument in relation to autonomy is that it stands in the way of medical professionalism hence, to respect and observe a patient's autonomy, negates the medical practitioner's discretionary powers and it contradicts the fiduciary relationship between the patient and the medical professional. This notion is referred to as medical paternalism – paternalism, is the belief that one's claim to autonomy must not supersede what is seen as good for him in a given circumstance. Autonomy may also potentially stand in contradiction with the professional's discretion of a medical practitioner. Such discretion is guarded in every profession as a way of ensuring that a professional has the freedom to offer service to the best of his/her ability and in accordance with the best industry practices. It is also necessary for ensuring that the professional can take full responsibility for his/her actions. Undue interference with a professional's discretion is thus often frowned at by different professions not only as a matter of professional pride but also due to pragmatic considerations.

In the case of *Nancy Cruzan v Director Missouri Department of Health,*[67] the United States court, trumped autonomy rights over paternalism. Here, a woman of 25 years of age got a serious injury in the year 1983 in a car accident. As a result, she got irreversible brain damage that led to her being in a permanently vegetative state. She was under a feeding tube as requested by her husband for a long time, but the condition did not change for some years. She was surviving physically with the help of artificial nutrition and hydration. After six years, within which

[62]*Supra.*
[63]*Supra.*
[64][2002] EWHC 901, [2002] MHLR 411.
[65] [2006] EWHC 1230 (Fam); [2006] 2 FLR 958.
[66] MHA, 1983, Cap. C20.
[67]*497 261 (1990*).

period her parent had assumed the position of her legal guardian, requested for the withdrawal of the feeding tube to let her die. The hospital refused and her parent filed a suit against the director of the department of health and the verdict turned out in favour of her parent because the patient's right to liberty which in this case means autonomy (self-determination), is superior to the state interest to protect life, and thus granted an order removing all life support.[68] This right to self-determination has been argued by Selvalingam as giving an individual power to control the manner, situation and the timing of his death.[69] In the same vein, the United States Supreme Court in 1981, made an interesting pronouncement about autonomy: 'No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others'.[70]

In clinical settings, the practitioner thus would desire that he/she be given a free hand to implement his/her professional skills and initiative without undue interference in so far as it conforms to the best industry practices. The *Code of Conduct for Medical Practitioners in Nigeria*[71] recognizes this right in *Rule 9* which by way of summary states that 'The principal objective of the medical or dental practitioner shall be the promotion of the health of the patient. In doing so, the practitioner shall also be concerned for the common good while at the same time according full respect to the human dignity of the individual'. However, with the patient also claiming autonomy, there arises the problem of reconciling two interests. The two interests may be described as the patient's personal autonomy and the medical personnel's professional autonomy (paternalism). Numerous arguments that substantiate and support medical paternalism as a viable ethical practice across the globe abound.

Proponents argue that doctors and other health workers have justified their grounds in support of paternalism because their act is for the patient's own good, even though the patient himself disagrees.[72] The physician's behaviour in such cases could be justified by classical utilitarian arguments which states that an act should be judged right or wrong according to the pleasure produced and the pain avoided and that according to the principle of utility, the moral end that should be sought in all that we do is the greatest possible balance of good over evil.[73] The notable proponents of this school of thought are John Stuart Mills and Jeremy Bentham. Doctors and other health care workers also mentioned that paternalistic restrictions are necessary because without them 'people or patients would behave irrationally' and thereby harm themselves.[74] Advocates of paternalism further argue and believe that individuals can be forced into being happy against their own expressed wishes and desires and that paternalism can be justified, if it provides great benefit or prevent major problems while disrespecting autonomy slightly.[75]

Furthermore, the advocates of paternalism maintain that it is justified since medical experts have the greatest capability of making the proper decision in their field of expertise, thus doctors should be permitted to override individual's/patient's decision in order to benefit that individual's overall health.[76] The advocates of paternalism further maintain that paternalism enables doctors and health care providers to right the wrongs of erroneous culture and religious practices that have found its way into medicine by virtue of autonomy[77] – right to self-determination. Advancing the argument further, they posited that doctors and other healthcare professionals are placed in an ethical bend as to fulfilling their duties to diagnose, treat and cure which at times conflict with the cultural and religious beliefs of patients.[78] For example, Jehovah witness doctrine is against receiving blood transfusions. Also some culture believes that illness is triggered by the loss of person's soul, instead of pathogenic process beliefs in order to

[68]B Rosenfeld, *Right to Die and Assisted Suicide*, 1st ed. (London: American Psychological Association, 2002).P. 34.
[69]M A R Selvalingam, *Physician-Assisted Death in England and Wales* (Newcastle University, 2014).p.110.
[70]D J Solove & N M Richards, 'Privacy's Other Path' [2013] (96) *George Washington Law Journal*, p. 124.
[71]2004. See generally Rule 9 which provides for the general principles of the ethics of medical and dental practices in Nigeria.
[72] J A Ayodele, *op. cit.*, p. 59.
[73]*Ibid.*,p. 59.
[74]*Ibid.*,p. 59.
[75]*Ibid.*,p. 59.
[76]*Ibid.*,p. 59.
[77]*Ibid.*,p. 59.
[78]*Ibid.*,p. 59.

give the patient the care that western medicine has taught them to be necessary to provide the patient with diagnosis and treatment.[79]

Finally, is the argument by the advocates of medical paternalism on the sanctity of the human life which states that paternalism helps to protect the sanctity of life at all cost not minding patient's autonomy or otherwise, since their aim or *von cent Origo* is to prevent harm and bring about pleasure or happiness.[80]

5. Autonomy as a Potential Negation of the Society's Common Interest

Patient's autonomy may negate the common interest of the community. The individual cannot be severed from his/her community. He is intrinsically part of it, he draws his being from it. This is more emphatic with African societies where communitarian lifestyle is still very strong. The individual does not live for him/herself alone but also lives for others – family, relatives and even friends. States therefore, seek to protect the interests of innocent third parties particularly when minor children are involved.[81] Thus, credence is given to the State to judicially intrude on a patient's right to autonomy in order to protect the rights of a third party.[82] There have been many cases, especially in the American jurisdiction, that have shown great respect for the state's interest in ensuring parental support of minor children and dependents.[83] This underscores the fact that the state is interested in the welfare of minor children and dependents who would suffer from the emotional and financial damage which may occur as a result of the decision of a competent adult to refuse lifesaving or life-prolonging treatment.[84] Thus, in *Holmes v Silver Cross Hosp of Joliet, III.*,[85] the court held that while the state's interest in preserving an individual's life was not sufficient, by itself, to outweigh the individual's interest in the exercise of free choice, the possible impact on minor children would be a factor which might have a critical effect on the outcome of the balancing process. Consequently, in the American Jurisdiction, a court ordered a competent adult to submit to a medical procedure on grounds of the state's interest in the protection of innocent third parties in the case of *Application of President & Directors of Georgetown College*.[86] In that case, the patient, aged twenty-five and the mother of a seven-month-old-child, was taken to the hospital for emergency care after having lost two thirds of her body blood from a ruptured ulcer, she and her husband were Jehovah's Witnesses and they refused to consent to the needed blood transfusion. When death without a transfusion became imminent, the hospital applied to the district court for permission to administer blood but this was denied. The hospital then appealed to the Circuit Court judge who gave permission for the transfusion because of a mother's 'responsibility to the community to care for her infant.' In coming to this decision, the court stated that 'The state, as *parens patriae*, will not allow a parent to abandon a child, and so it should not allow this most ultimate of voluntary abandonments. The patient had a responsibility to the community to care for her infant. Thus, the people had an interest in preserving the life of this mother'.[87]In the year 1987, the New Jersey Supreme Court in the case of *Matter of Farrel*,[88] summarized the law succinctly thus:

> When courts refuse to allow a competent patient to decline life-sustaining treatment, it is almost always because of the state's interest in protecting innocent third parties who would be harmed by the patient's decision. For example, courts have required competent adults to undergo medical procedures against their will if necessary to protect the public health, or to prevent the emotional and financial abandonment of the patient's minor children.[89]

Such is the justification for this judicial intrusion that even when the refusal to undergo a medical procedure is on religious grounds especially with regard to minor children, the courts have not hesitated one bit to declare in favour

[79]*Ibid.*,p. 59.
[80]*Ibid.*,p. 59.
[81]E O C Obidimma &A E Obidimma, *op cit.*, p. 160.
[82]*Ibid.*,p. 160.
[83]*Ibid.*,Pp. 160-161.
[84]*Ibid.*,p. 161.
[85]340 F. Supp. 125 (D.III. 1972).
[86] 331 F. 2d 1000, 1008 (D.C.Cir), cert. denied, 377 U.S. 978, 84 S.Ct. 1883, 12 L.Ed. 2d 746 (1964).
[87]At Page 1007.
[88]529 A. 2d 404, 412 (N.J. 1987).
[89]See also, *Holmes v. Silver Cross Hospital*, 340 F. Supp. 125 (D.III. 1972) at P. 130 where the court noted that a father can similarly be compelled to undergo a blood transfusion if his refusal would devastate his dependents, and John F. Kennedy Memorial Hosp. v Heston, 58 N.J. 576, 279 A. 2d 670 (1971) where the court permitted blood transfusion for a pregnant woman in the interest of her child.

of the patient's dependents or innocent third parties.[90] In *Prince v Massachusetts,*[91] the U.S. Supreme Court in this regard, made the point when it stated that '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 themselves'.[92] The above sentiment in the earlier cases was echoed by the Supreme Court of Nigeria when it affirmed the earlier decision of the Court of Appeal in *Esabunor v Faweya*[93] when it stated that although a person has a right to choose a course for his or her life, that right is not available to determine whether her son should live or die on account of her religious belief. The net effect of the foregoing postulation is that the courts would, for the purpose of protecting innocent third parties, make an order permitting the administration of medical procedure against the will of a competent adult patient.[94]

6. Conclusion

Gone are the days when a 'trust me, I am a doctor approach' guided patient/doctor relationship. Today, medical practitioners must first seek and obtain the informed consent of a patient before administering any treatment on him/her. This is *in tandem* with the principles of biomedical ethics to wit: autonomy, beneficence, non-maleficence and justice. However, autonomy as conceptualized within the context of the individualism of Western societies may not be fit-for-purpose in an African context like Nigeria. Thus, it has been observed that the peculiarities of the communitarian lifestyle of an African constitute a problem to autonomy as understood in Western climes. In Nigeria, this problem manifests in a number of factors and practices.

[90]E O C Obidimma & A E Obidimma, *op cit.*, p. 161.
[91]321 U.S. 158 (1944).
[92]Pp. 166, 170 of the report.
[93][2019] 7 NWLR (Pt. 1671) 316.
[94]E O C Obidimma & A E Obidimma, *op cit.*, p. 161.