PATIENT AUTONOMY AND INFORMED CONSENT: BALANCING SELF-DETERMINATION WITH MEDICAL RESPONSIBILITY IN HEALTHCARE DECISION-MAKING[1]

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Abstract
The primacy of patient autonomy in contemporary healthcare has established it as a bedrock principle, reflecting the right of individuals to self-determination in medical decision-making. Autonomy is deeply rooted in the philosophical ideal of self-determination, underscoring the patient's capacity to make independent choices regarding their health, free from external coercion. This principle is operationalized through informed consent, a mechanism that obligates healthcare providers to disclose comprehensive information about treatment options, risks, benefits, and alternatives, thereby enabling informed decision-making. Informed consent serves as a dual construct—a legal mandate and an ethical safeguard of patient autonomy. It signifies a departure from the historic dominance of medical paternalism, which often prioritized physician judgment over patient preference. Yet, in practice, achieving a balance between patient autonomy and the duty of medical responsibility is fraught with complexity. The aim of this study is to critically examine the extent to which patient autonomy can be preserved in healthcare decision-making without compromising the ethical duty of healthcare providers to ensure patient welfare. The methodology adopted by this work is doctrinal method of legal research. The source of data collection for this work are primary sources of law such as statutes and conventions, case laws; and secondary sources of laws such as internet materials, journals articles and textbooks of renowned authors. Through a comprehensive analysis of relevant statutes, international legal instruments, case laws, journal articles etc., the researcher found that absolute autonomy is challenging when patients are unable to fully comprehend the ramifications of medical decisions. In cases involving mental incapacity or refusal of life-saving treatment, healthcare providers must navigate ethical dilemmas where protecting patient well-being might necessitate overriding absolute autonomy. The researcher recommended among other things enhancing informed consent processes through simplified communication strategies, providing decision-making support for patients, and creating guidelines to manage situations where autonomy conflicts with medical responsibility

1.0 INTRODUCTION

1.1 In contemporary healthcare, the principle of patient autonomy has become foundational, shaping the ethical and legal framework that governs the relationship between patients and medical practitioners. Rooted in the philosophical ideal of

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self-determination, autonomy reflects the right of individuals to make independent decisions about their health and medical treatment, free from external coercion or undue influence. In healthcare, this principle empowers patients to be active participants in decisions concerning their own well-being, recognizing their ability to guide their care according to personal values and preferences.

1.2 The concept of informed consent is the practical expression of patient autonomy. It requires healthcare providers to ensure that patients receive adequate information regarding the nature, risks, benefits, and alternatives to any proposed treatment, enabling them to make informed decisions. Informed consent represents not only a legal requirement but also an ethical obligation that underscores the patient's right to self-governance. It marks a shift from the historical dominance of medical paternalism, where healthcare decisions were largely made by physicians on behalf of their patients, often without sufficient consultation or respect for the patient's wishes.

1.3 However, the application of patient autonomy and informed consent is not without challenges. Many patients, despite being given the opportunity to exercise autonomy, may struggle to fully understand complex medical information due to the specialized nature of healthcare. In such cases, their capacity to make fully informed decisions may be impaired by illness, emotional distress, or limited medical knowledge. This raises critical questions about the extent to which autonomy can be exercised in healthcare and whether certain limitations may be justified to protect patients from making harmful decisions.

1.4 Moreover, the tension between patient autonomy and the healthcare provider's duty to act in the patient's best interest is often at the center of ethical and legal debates. Situations where patients refuse life-saving treatment, or when they lack the mental capacity to make informed choices, challenge the notion of absolute autonomy. Medical professionals are confronted with the ethical dilemma of respecting a patient's right to refuse treatment while upholding their professional obligation to promote well-being, leading to a delicate balance between autonomy and medical paternalism.

1.5 This study critically examines the role of patient autonomy and informed consent in healthcare decision-making. It explores the limits of autonomy in practice, particularly when confronted with the complexities of medical paternalism and ethical dilemmas in patient care. Through a comprehensive analysis of legal doctrines, ethical principles, and practical applications in healthcare, the study seeks to understand how the balance between individual rights and medical responsibilities is navigated in various medical contexts. In doing so, it aims to offer insights into the evolving landscape of healthcare decision-making and the ongoing challenges of ensuring patient autonomy while safeguarding health outcomes.

2.0 The Concept of Autonomy in Healthcare: Origins and Evolution

2.1 The word" autonomy" is originally a Greek word meaning self-rule or self-governance.[2]It is a concept that denotes the fundamental right of an individual human person to enjoy a certain reasonable degree of independence in making personal choices. It points to the right of the individual to non-interference in his/her thoughts, beliefs, judgments, decisions and actions. It presupposes the existence of a personal space that is sacred and inviolable which an individual does not lose without suffering some violence to their personal dignity.[3]

It is the basis of many rights including the right to life, freedom of religion, thought and conscience, right to freedom from torture, degrading and inhuman treatment and right to freedom of movement among others. These rights are founded on the notion that each person possesses a certain existential space that ought not to be interfered with.[4]

As such autonomy has its basis in the idea of human dignity which holds that every human person is naturally endowed with irrevocable worth by virtue of their being human and that this value must be reckoned with in any dealing with such a person.[5]

2.2 However, autonomy, like other ideological concepts has not been without some variations in the way it has been understood by various people. The major issue in these variations has been the extent to which individual autonomy can be sustained in the face of claims by other interests, such as the community and other individuals.[6] The patient's consent to medical treatment is the pivot around which patient's autonomy revolves. Medical treatment which is given without consent constitutes trespass to the person,[7] save in exceptional circumstances.

However, proof of consent is a defence to an allegation of trespass to person. The burden of proof is on the defendant.[8]

In order to provide an answer to a claim in trespass, it must be shown that the consent given related to the treatment in question, that it was given voluntarily, that the patient was appropriately informed before he consented and that he had capacity in law to consent.[9]

The questions then are: are there limits to a patient's autonomy in making medical decisions? How much control should patients have over their healthcare choice? Why would a patient not want to have control over his or her healthcare decisions? When might a patient not be able to fully control their care choices? The most intuitive answers to the above question which one readily gives can be summarized

2 C W PrinceWill and others, '*Autonomy and Reproductive Rights of Married Ikwere Women in Rivers State, Nigeria*' *Journal ofBiothetical Inquiry* (2017) 14. 205

3 C W PrinceWill*et al.*,

4Adetunji, *Rights, Liberties and Privileges. A philosophical Approach* (Ibadan, Scepter prints 2011). 119

5Ibid, 119

6 Ibid, 121

7*Hamilton v. Birmingham Regional Hospital* (1969) 2 BMJ 456 and *Appleton v. Garret* (1996) 1 P. 1 QR 1

8Re F '*mental patient: sterilization*' (1990) 2 A.C.I.

9*Reibl v. Hughes* (1980) 114 DLR (3d) 1@9

as possible. The goal is to move care in the right direction. The ethical principle of autonomy should be considered when it has features which relate to people, self-determination or self-governance, all of which are relevant to making healthcare decisions.

2.3 In further answers to the questions posed above, two concepts are apt. Firstly, an individual must have adequate knowledge to explore and examine all options relevant to the medical decision that needs to be made. Most often, this specialized knowledge is beyond the scope of most patients. Therefore, they must rely on the healthcare professionals to present them with the information (in a simplified version) they lack. Even patients, who may be quite knowledgeable about their illness, may not know the whole story. For example, a physician who becomes a patient may lose objectivity about specific details of his treatment. It is the obligation of the healthcare professional who is proposing treatment to provide the relevant information that is needed to enable the patient to make an informed decision. Secondly, the patient is often in an impaired state that makes fully deliberative decision making difficult at best. The patient could be in pain, emotionally traumatized or in some way not up to making a fully unemotionally rational decision. The ability to give informed consent may be impaired by illness, denial and multiple factors. The patient's autonomy is also limited when its exercise causes harm to someone else or may harm the patient. When the harm is sufficiently grave or its exercise violates the moral principles and conscience of the medical professional, they override principle of autonomy. In the case of In *Re T (Adult: Refusal of Treatment)*.[10] Lord Donaldson M.R. summarized the relevant principles, thus:

i. Prima facie, every adult has the right and capacity to decide whether or not he will accept medical treatment, even if a refusal may risk permanent injury to his health or even lead to premature death. Furthermore, it matters not whether the reasons for the refusal were rational or irrational, unknown or even non-existent …. However, the presumption of capacity to decide, which stems from the fact that the patient is an adult, is rebuttable.

ii. An adult patient may be deprived of his capacity to decide by long-term mental incapacity.

iii. If an adult patient did not have the capacity to decide at the time of the purported refusal and still does not have that capacity; it is the duty of the doctors to treat him in whatever way they consider, in the exercise of clinical judgment, to be in his best interests.

iv. Doctors faced with a refusal of consent have to give very careful and detailed consideration to what was the patient's capacity to decide at the time the decision was made. It may not be a case of capacity or no capacity. It may be a case of reduced capacity. What matters is whether at that time the patient's capacity was reduced below the level needed in the case of a refusal of that importance, for

10(1993) Fam. 95 @ 115 – 116.

refusals can vary in importance. Some may involve a risk to life or of irreparable damage to health. Others may not.

2.4 In this regard, patient's right of autonomy has limitations. On the contrary, paternalism presupposes that one's claim to autonomy must not supersede what is seen as good for him in the circumstance. Paternalism occurs when a physician or any other healthcare professional makes decisions for a patient without the explicit consent of the patient. It is a dominant attitude of one over another. It was widely practiced because physicians are expected to make the best decision for the patient. It is to act for the good of another without that person's consent as parents do for their children.[11] The key thing in paternalism is that what is seen as serving one's welfare takes precedence over one's autonomy. Therefore, with paternalism, autonomy is easily dispensed with.

2.5 Medical paternalism is a set of attitudes and practices in medicine in which a physician determines that a patient's wishes or choices should not be honoured. These practices were current through the early to mid-20th century and were characterized by a paternalistic attitude, surrogate decision-making and lack of respect for patient autonomy. It is almost exclusively undertaken with the intention of benefiting the patient, although this is not always the case. In the past, paternalism was considered as an absolute medical necessity, as there was little to no public understanding of medical procedures and practices. However, in recent years, paternalism has become limited and blind faith in doctors' decisions has come to be frowned upon.

3.0 Limitations of Autonomy in Medical Decisions: Ethical and Legal Perspectives

3.1 Basically, autonomy is about allowing patients to decide or be part of the decision making on their health.[12] This basic and significant aspect of clinical care encompasses decisions and actions that have potential implications for the autonomy of the individual patient. Most importantly such implications, most often, entail serious consequences including death or permanent damage to health. Patient autonomy involves right to make decisions concerning his or her health without the doctor or any healthcare giver trying to influence the decision. However, the doctor or healthcare giver can educate the patient. There are several aspects of patient's autonomy. These include finding a right doctor or health giver a patient will be comfortable with. A right doctor will naturally support the patient's autonomy. Secondly, receiving the kind of care that will be comfortable for the patient. Thirdly, the patient's right to get answers he/she needs to understand the treatment reflects on his autonomy.[13] The ability to recognize and foster patient autonomy, and its various dimensions widely considered as an important clinical competency

11J AAyodele, 'The Realities Surrounding the Applicability of Medical Paternalism in Nigeria' *Global Journal of Social Science* (2015)14. 55.

12 J A Ayodele (n, 10), 55

13C A Bernstein 'Take Control of Your Healthcare (Exert Your Patient Autonomy)' [2018] <https://www.health.harvard.edu.takecontrolofyourhealthcare(exertyourpatient autonomy> accessed August 11, 2021

for physicians. However, its conception in the medical and ethical literature as its practical implementation still raises ongoing challenges for practice of medicine.

3.2 Naturally, there is a moral or ethical issue vis-a-vis legal implications involved in right of patient to his or her autonomy. The need for patient autonomy, empowerment and choice has become central to healthcare. A physician's intent for beneficence conflicts, most often, with patient's autonomy. This conflict has led to the development of documentation in which the patient must demonstrate their understanding of the predictable consequences of his decision to act against medical advice. It has been argued[14] that in recent years, the triumph of autonomy has made paternalist interventions increasingly problematic. The value of patient's right to self-determination and the practice of informed consent are considered supremely important in present day healthcare ethics. In general, the idea of 'doctor knows best' has become more and more suspicious. This has left a situation in which paternalist medicine seems difficult to reconcile with respect for patient autonomy.

3.3 In other words, the fundamental principles of ethics are: beneficence, non-malfeasance, autonomy and justice. Beneficence and non-malfeasance can be traced back to the time of Hippocrates "to help and do no harm while autonomy and justice evolved later. That is to say with passage of time, autonomy and justice gained acceptance as important principles of ethics.

The principle of beneficence is the obligation of physician to act for the benefit of the patient and supports a number of moral rules to protect and defend the right of others, prevent harm,

3.4 Non-maleficence is the obligation of a physician not to harm the patient. This simply stated principle supports several moral rules: do not kill, do not cause pain or suffering, do not incapacitate, do not cause offence and do not deprive others of the goods of life. The practical application of non-maleficence is for the physician to weigh the benefits against the benefits against burdens of all interventions and treatments, to eschew those that are inappropriately burdensome and to choose the best course of action for the patient. A physician's obligation and intention to relieve the suffering of a patient by the use of appropriate drugs.[15] The difference between beneficence and no maleficence is the positive language of the latter.[16] The philosophical underpinning for autonomy is that all persons have intrinsic and unconditional worth, and therefore, should have the power to make rational decisions and moral choices and each should be allowed to exercise his or her capacity to self – determination. The dictum is: every human being of adult years and sound mind has a right to determine what shall be done with his own body.

3.5 Justice is generally interpreted as fair, equitable and appropriate treatment of persons. Of the several categories of justice, the one that is most pertinent to clinical ethics is distributive justice. It refers to the fair, equitable and appropriate

14T Nys, *et al*, *Autonomy & Paternalism: Reflections on the Theory and Practice of Healthcare* (Peeters Publishers, 2007)

15T Nys, *et al,* (n, 13)

16Ibid

distribution of health-care resources determined by justified norms that structure the terms of social cooperation.

3.6 To allow patients to be autonomous; decision – makers, physicians are supposed to disclose and share information related to all treatment, procedures and risks. Advocates of advocates based their argument on informed consent. The disclosure of information should be according to the reasonable person standard or reasonable patient standard rather than the average competent physician standard.[17]

4.0 Informed consent

4.1 The idea of consent is based on the right of self – determination. This right as established by Justice Cardozo in *Schlowndorff .v. Society of New York Hospital* to the effect 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 his patient's consent commits an assault for which he is liable in damages. This is true, except in cases where the patient is unconscious and where it is necessary to operate before consent can be obtained.[18]

Consent is said to be informed when it is given after knowing by the patient the nature of the medical treatment involved. Consent or refusal of treatment usually based on privacy, liberty and religious freedom can only take place when the patient for the medical treatment understands:

i. The diagnoses and name of the treatment, procedure, or medication;
ii. Intended purpose;
iii. The hope for benefits of the proposed regimen (without guaranteeing the outcome);
iv. The material risks of any of the treatment;
v. Alternative treatment if any;
vi. The prognosis of the recommended care procedure, or medication is refused.[19]

5.0 The Role of Capacity in Exercising Autonomy

5.1 There are arguments against medical paternalism which us based on a number of claims.

5.2 The major premise of the argument for paternalism is that medical expert possesses the requisite special knowledge and so is in a better position to take decisions that will produce the best result. In other words, medical professionals claim self-evident epistemic authority over their patients in medical matters; they really know

17S Subramani 'Patient Autonomy within Real or Valid Consent: Samira Kohli's Case' [2017] <https://pubmed.ncbi.nim.nih.gov>pmc. accessed 18 August 2021.

18105 N.E 92(NY1914) @93

[19]A Meisel, *The Right to Die* (vol. 2, New York: Wiley, 1989)

the best in the sense that they do possess more knowledge concerning injuries, diseases, and their cure than most patients. The question then is: are there limits to a patient's autonomy in making healthcare decisions?

This is a question healthcare professionals have to answer almost every day. As they work with patients and families who are making decisions, the goal is to move health care in the right direction. It is important to state that a patient can have control over his or her healthcare decision as much as possible. There is no doubt decision making is an important factor in the concept of autonomy.

5.3 This refers to one's capacity to exercise his or her right to make choices at any point in time. In order words, medical decision – making capacity is the ability of a patient to understand the benefits and risks of, and the alternatives to, a proposed treatment or intervention (including no treatment); capacity is the basis of informed consent.[20] There are four factors to determining or establishing decision – making capacity. Generally, a patient of full age and capacity can effectively refuse medical treatment even when it is necessary to save his life. Depending upon its terms, that refusal may include foreseeable future medical treatment even in the event that the patient later becomes incompetent to give or withhold consent. Under the common law, medical treatment in the absence of consent may be given in an emergency.[21] This based on the principle of necessity. It applies when a person is unable to make any decision. For example, either because such a person is unconscious or is mentally handicapped and the treatment is in his best interests.[22] In Nigeria, there is paucity of judicial decisions with respect to decision – making capacity of a patient. The reason is not far – fetched. The fundamental reason is religion.

5.4 The above rights are also preserved in Sections 37 and 38 of the Constitution of the Federal Republic of Nigeria, 1999 (as amended). Since the patient's relationship with the practitioner is based on consensus, it follows that the choice of an adult patient with a sound mind to refuse informed consent to medical treatment, barring state intervention through judicial process, leaves the practitioner helpless to impose a treatment on the patient. The Supreme Court put it beyond per adventure in the case of *Okonkwo v. Medical and Dental Practitioners' Disciplinary Tribunal*, [23]that the constitutional right to privacy includes right of a competent, mature adult to refuse treatment that may prolong one's life even though refusal may seem unwise, foolish or ridiculous to others. If a competent adult, exercising his right to reject life – saving treatment on religious grounds thereby chooses a path that may ultimately lead to his death, what meaningful option is the practitioner left with, other than perhaps, to give the patient comfort? In several cases the courts have refused to override the patient's decision. In others, they have found ways round the problem of the paramountcy of the patient's consent. What is important is that

20<https://www.aafp.org>afp> accessed 24 August 2021

21See *Re-F. (mental patient: sterilization)* (1990) 2 A.C, 1 @ 55

22See *Re-F (mental patient: sterilization)* supra.

23 (2001) NGSC 14

in no case has the decision to override the patient's decision been left with the medical practitioner.

5.5 The decision making is predicated on two factors: mental and physical state of the patient. Mental state refers to a person's intellectual capacity due to considerations of age or mental health. Physical state refers to bodily health which could render a patient incapable of physical or mental exercise. In either of the two cases, what presents itself is in capacity to make decisions. This means that the patient lacks the mental or physical ability to make a choice in a given situation. The foregoing was the basis of the decision in Re T Adult: (Refusal of Treatment). [24]This situation also presented itself in the case of Re C (Adult: Refusal of medical Treatment), [25]where a chronic paranoid schizophrenic adult refused to consent to the amputation of his gangrenous foot. He was granted an injunction against the amputation of his foot without his express written consent. The court had to consider whether or not C was competent to give or withheld consent at the time of his refusal. The court analyzed the process of decision making capacity into three stages: comprehending and retaining treatment information, believing it, and weighing it in order to make an informed choice. Applying that test, the court found that the patient's general mental capacity was not so impaired by his schizophrenia that he was incapable of understanding the nature, purpose and effects of the proposed treatment, so that the presumption of competence (his right of self – determination) was not displaced and its expression governed all doctors with notice of it. In *R .v. Collins and Ashworth Hospital Authority, ex parte Brad*y[26] it was held that forcible feeding against a patient's will was not sanction- able on the basis that the patient had been incapacitated in all his decisions about refusing food by a mental disorder, and that the doctors were legally empowered to supply medical treatment in his best interest in accordance with their clinical judgment.

5.6 Incapacity to make decision could be actual or constructed. When it is actual, it means that the said patient lacks ability to carry out those concrete acts of mental and physical nature involved in decision – making. These acts include hearing/seeing/reading and understanding the communication of the health expert, thinking and making judgment based on it, and communicating this decision through speaking, writing or via any other form of sign making. On the other hand, incapacity to make decision is constructed when the patient can actually exercise the above physical and mental acts but is adjudged as incapable of exercising them prudently. This obtains in case of children and mentally challenged patients. It is in these situations that it becomes much more problematic to establish who lacks capacity as subjective judgments naturally inherent in each individual's idiosyncrasies and standards of culture will inevitably interfere.

24(1994) 1 WLR 290

25(1994) 1 ALL ER 819 (QBD)

26 (2000) Lioud's Rep. med 355

5.7 However, to establish lack of decision making capacity is generally problematic.[27] It has been suggested[28] that there are four key components of capacity evaluation: communicating a choice, understanding, appreciation and rationalization/reasoning. Communication entails that the patient needs to be able to express a treatment choice and this decision needs to be stable enough for the treatment to be implemented. Though changing one's decision in itself would not bring a patient's capacity into question so long as the patient was able to explain the rationale behind the change. However, frequent changes back and forth in decision making could be indicative of an underlying psychiatric disorder or extreme indecision which might bring capacity to question.

In the spheres of understanding, the patient needs to recall conversations about treatment, to make the link between casual relationships, and to process probabilities for outcomes. Problems with memory attention span and intelligence can affect one's understanding.

5.8 As per appreciation, the patient should be able to identify the outcomes as things that will affect him or her directly. A lack of appreciation usually stems from a denial based on intelligence (lack of a capability to understand) or emotion, or a delusion that the patient is not affected by this situation the same way and will have a different outcome.

5.9 With respect to rationalization or reasoning, the patient needs to be able to weigh the risks and benefits of the treatment options presented to a conclusion in keeping with their goals and best interests, as defined by their personal set of values. This often is affected in psychosis, depression, anxiety, phobias, delirium and dementia.

5.10 Basically, familiarity with the care legal standards of capacity (i.e communication of choice, understanding, appreciation and reasoning) will improve a healthcare giver the ability to identify patients who lack capacity, understanding and applying the defined markers, most often, provides a sufficient capacity evaluation in itself.

5.11 Equally, deciding that a patient lacks capacity is not an end in itself, and the underlying cause should be addressed. Certain factors, such as infection, medication, time of day and relationship with the clinician doing the assessment, can affect a patient's capacity. These should be addressed through treatment, education and social support whenever possible in order to optimize a patient's performance during capacity evaluation. If the decision can be delayed until a time when the patient can regain capacity, this should be done in order to maximize autonomy.[29]

5.12 Therefore, the contextual questions: whether lack of capacity in one instance mean lack of capacity in all instances; can one who lacks capacity by reason of age for instance: in a complicated medical procedure like surgery also automatically lack capacity to mere swallowing of a pain killer tablet; does mere proof of mental

27 C P Selinger, 'The Right to Consent: Is it Absolute?' *British Journal of Medical Practice*; (2009) (2) (4). 50

28 J G Dastidar and AOdden '*How Do I Determine if my patient has Decision – making capacity*?' (2011) The Hospitalist<https://www.the hospitalist.org.> accessed 26 August 2021

29 J G Dastidar and A Odden (n, 24)

illness automatically establish lack of decision-making without consideration of the type of the mental challenge. For example, can a serious mental illness like schizophrenia considered incapable of decision making from another suffering a less serious mental challenge like compulsive-obsessive neurosis; or one whose insanity symptoms are sporadic be considered incapable at all times, when he/she experiences lucid intervals from such symptoms. All these medical situations confront medical personnel when dealing with the issue of decision making capacity of patients.

5.13 A person lacks capacity if his/her mind is impaired or disturbed in some way. This means that such a person is unable to make a decision concerning his health care at the time. Examples of how a person's brain or mind may be impaired include mental health conditions such as schizophrenia or bipolar disorder, dementia and severe learning disabilities.

5.14 Deciding for those who lack capacity should have been straight forward moral duty were it not for the legal intricacies. Since morality is a matter of private conscience, it would have been the case that a concerned party will simply proceed to act according to his/her personal moral conviction and sense of duty without having to contend with the often difficult questions posed by the legal standard.

5.15 Suffice it to say that there are two components to this. The first is deciding who is competent to make the decision and the second is how to approach the decision in such a way that the best interest of the patient is served.[30]

5.16 Decision making capacity and legal competence are terms often used interchangeably in a hospital setting to describe an individual's ability to make consequential decisions regarding themselves, as a manifestation of their autonomy. More specially, however, capacity describes a patient's ability to make autonomous decisions regarding their care, as determined by a physician whereas competence is a legal term that describes a person's ability to participate in legal processes. Decision-making capacity is the patient's ability to understand a proposed intervention, its benefits risks and alternatives including the option of no treatment and make autonomous decisions regarding his case. There are different theories with respect to decision making capacity.

6.0 Problems of the Concept of Autonomy

6.1 One of the problems arising from concept of patient's autonomy is Discharge against medical advice (DAMA)[31]. This is a situation in which a patient chooses to leave the hospital before the treating physician recommends discharge. It is a problem for many medical practitioners who treat hospitalized patients. Leaving the hospital against medical advice may expose the patient to risk of inadequately treated medical problem which may result the need for readmission. The ethical dilemma that this issue is conceptually and relatively straight forward. Most

30Selinger, (n, 25). 50

31Also known as signing against medical advice (SRMA); learning against medical advice (LAMA); or discharge against own risk (DAOR)

medical practitioners struggle with the desire to respect the patient's wish and his or her right to self-determination or autonomy while attempting to do what they think best for the patient (to act with beneficence).[32]

6.2 There is no clear cut answer to the question between principles of beneficence and patient autonomy which takes precedence. The principles must be examined based on their peculiarities. The important factors to consider include setting, cost implication for the healthcare system and the patient's competence/decision making capacity, family support system and best interests.[33] Beneficence is an act of charity, mercy and kindness with a strong connotation of doing well to others including moral obligation. In the context of professional-client relationship, the professional is obligated; favour the well –being and interest of the client.

6.3 They proposed that an informed consent form should be signed by the patient or his/her surrogate decision maker before being allowed to leave the hospital.[34] Such consent form should be written in a simple language. In the consent form, the patient will understand of the disease condition, possible consequences of premature discharge and the reasons for DAMA should be highlighted. However, in cases where the doctor is not convinced that the patient fully understands the situation or that the surrogate decision-makers are protecting the patient's best interests, he or she can obtain a court order permitting the involuntary or compulsory hospitalization as was done in the case of *Esanbanor & Anor v Faweya & Ors*.[35]

6.4 Accordingly, an adult person who is conscious and in full control of his mental capacity and is of sound mind has the right to either accept or refuse medical treatment, including blood transfusion. In such a case, the hospital has no choice but to respect the person's wishes. However, different considerations apply to a child because a child is incapable of making decisions for himself and the law is duty bound to protect such a person from abuse of his rights even by the child's parents. So, when a competent parent or a person in loco parentis refuses medical treatment or blood transfusion for a child on religious grounds, the court should step in.

The court should take a decision after considering the child's welfare, i.e. saving the life and the best interest of the child.

6.5 These considerations outweigh whatever religious belief the parent of the child may have about any form of medical treatment because the child may grow up to reject his parents' religious beliefs. And the decision of court should be to allow the administration of blood transfusion especially in life threatening situations. In this case, the 1st appellant was then only one-month old, was incapable of deciding for himself. On the other hand, the 2nd appellant, his mother acted on her religious belief. In the circumstance, the 5th respondent was right in granting the said 4th

32D J Alfandre; 'I'm Going Home: Discharges Against Medical Advice'. Do1: https://doi.org/10.4065/84.3.255> accessed August 9, 2021

33 Ibid. 324

34 D J Alfandre (n, 29) 333

35(2019) 7 NWLR (pt. 1671) 316

respondent's application, which allowed the 1st respondent to save the life of the 1st appellant.

6.6 The law exists primarily to protect life and preserve the fundamental right of its citizens inclusive of infants. The law would not override the decision of a competent mature adult who refuses medical treatment that may prolong his life but would readily intervene in the case of a child who lacks the competence to make decisions for himself. Section 13 of the Child's Right Act provides for the right to health and health services of the child. Particularly, Section 13(2) provides that every government, parent, guardian, institution, service, agency, organization or body responsible for the care of a child shall endeavour to provide for the child the best attainable state of health. In this case, having regard to the provisions of the Child Right's Right Act, it would have amounted to a great injustice to the 1st appellant if the court stood by and watched the 1st appellant being denied of basic treatment to save his life on the basis of the religious conviction of his parent (2nd appellant).

6.7 Section 59(1) of the Child's Right Act, 2003 provides that where it appears to the court in proceedings in which a question arises as to the welfare of a child, that it may be appropriate for a care supervision order to be made with respect to that child, the court may direct the appropriate authority to undertake on investigation of the child's circumstances.

6.8 Comparatively, in the case of *Okekearu .v. Tanko*[36] the Supreme court held that a consent form signed by an aunt of a 14 years boy (the respondent) for the appellant (a doctor) to carry on whatever "treatment" on the respondent's injured finger, did not amount to a valid consent on the ground that the respondent at that material time was a rational human being. The appellant amputated the respondent's finger which was severally damage and based on his aunt's consent, the appellant went on to amputate it. The Supreme Court held him liable for battery. The Supreme Court appeared to have followed the Canadian case of *Valmol. v. Ashmore*[37] where the question of who has the right to give consent was considered. In that case a 16-year-old girl underwent surgery to remedy narrowing of her aorta; in the course of difficulties in the operation she suffered paraplegia and damage to laryngeal nerve. The Judge held that the operation was not negligently carried out, and that proper consent had been obtained from the parents. The court of Appeal held, by a majority, that the appeal should be allowed on the basis that the patient herself should have had the appropriate explanation about the risks and advantages of the operation and that had this happened she would have probably have opted for a more conservative approach.

6.8 In general, the question of patient's autonomy, DAMA, best interest and decision making capacity should be promoted within the parameters of strong ethics practices in informed consent and exploring the roles of surrogates. This becomes

36(2002) 15 NWLR (pt. 791) 466

37(1999) 168 D.L.R. (4th) British Columbia (CA)

significant because physicians also have a fiduciary and contractual obligations to promote the patient's best interest by recommending medically appropriate care. [38]

6.9 Osamor and Grady [39] similarly engaged the issue of autonomy in a matrimonial setting, this time, with emphasis on joint decision-making by couples and the circumstances under which such decisions should be respected as compatible with autonomous decision-making. The writers proceeded on the assumption that the extent to which couples' joint decision-making might be deemed ethically acceptable will vary depending on the context; and considering that in many traditional marriages, the woman is the less dominant partner. They went on to consider a spectrum of scenarios of couples' joint decision-making about a woman's own health care that move from those that are acceptably autonomous to those that are not consistent with respecting the woman's autonomous decision-making.[40]The study found that to the extent that there is evidence that both members (a couple) understand a decision, intend it, and that neither completely controls the other, couples' joint decision-making should be viewed as consistent with the principle of respect for the woman's autonomy. Conversely, it was also found that certain decisions are made by the man without the woman's input and this situation represents domination of one partner by the other.

6.10 While the above study is certainly relevant to the question of autonomy in clinical setting, it does not address the question of incapacity to make decision on the part of the person possessing the autonomy. Its scope was limited to how much the husband-wife relationship in a patriarchal setting affects autonomy and decision-making. Also, while the research dominantly embodies sociological flavor, its legal flavor is at best very tenuous with the researchers making no direct reference to the relevant legal provisions.

6.11 The study by Princewill, Jegede, Nordstrom, Lanre-Abass and Elger[41] sought to examine women's exercise of autonomy in terms of participation in health related research. The study was based on the assumption that various factors tend to limit autonomy amongst the Yoruba women of western Nigeria regarding decision to participate in such research. Hence, the researchers proceeded to explore the experience and understanding of autonomy by Yoruba women focusing on factors that affect their autonomous decision-making in research participation. An exploratory qualitative approach comprising four focus group discussions, 40 in-depth interviews and 14 key informant interviews were used. Content analysis was employed for data analysis. Findings showed that the understanding of the concept of autonomy varied amongst the Yoruba women. Patriarchy, religion and culture were discovered to have negative impact on the autonomy of women in respect to research participation. Important findings of the study include:

38Ibid; p. 210.

39P E Osamor, & C. Grady, 'Autonomy and Couple' Joint Decision-Making in Healthcare' [2018] (19) BMC Med Ethics; p. 193https://www.nebi.nih.gov/pmc/articles/PMC5765707/accessed 6 June 2018

40 Ibid, 210

41Princewill, et al,(n. 1)

i. Male dominance is strongly emphasized by religious leaders who should teach equality; and
ii. While men feel that by making decisions for women, they are protecting them, the women on the other hand see this protection as a way of limiting their autonomy.[42]

6.12 This study, though related to autonomy and decision making, does not treat the subject in the context of clinical settings i.e. decision-making by patient. Nevertheless, its relevance to the subject of study here lies in the fact that autonomy, whether viewed in the context of a research setting or clinical setting, still has the same legal basis. However, admittedly, the researchers failed to precisely situate their study within the legal framework of Nigeria; they merely treated autonomy universally without anchoring it on any specific legal tradition such as the Nigerian jurisprudence.

6.13 Beyond gender, Aniaka[43] examined generally the socio-cultural challenges to informed consent in clinical setting in Nigeria. The investigation proceeded from the belief that a 'full realization of autonomy in the Nigerian legal system is severally constricted by sociological and cultural factors' and of 'particular concern is the impact of oppression which may arise from socialization.[44] It is the researcher's conviction that a sustained focus on improving patients' rights through informed consent without addressing the impediments posed by the social environment from which a patient operates will undermine full realization of patient's autonomy. The study found that factors that have been identified in bioethical literature as constraining individual's autonomous capacity, thus vitiating consent, include duress, coercion, undue influence and misrepresentation. However, the influence of oppression on a patient's choice, according to the findings, is often overlooked.

6.14 Also the influence of patriarchy in relationships between a husband and wife in Nigeria, especially as it relates to decision-making about the wife's reproductive health is identified as a manifestation of oppression. "It is either that the husband decides the nature of treatment the wife receives, or the pressure to conform to the societal norm which places premium on motherhood and the male gender, forces her to make certain choices.[45]

7.0 Conclusion

7.1 Ultimately, the ongoing tension between patient autonomy and medical paternalism reflects broader ethical dilemmas in healthcare. The growing emphasis on patient-centered care demands that healthcare professionals respect the patient's voice

42Princewill, et al,(n. 1)

43O Aniaka, '*Patients Right and the Socio- Cultural Challenges to Informed Consent in Nigeria'*<file:///C:/Users/Downloads/Patient%20Right%20and%20the%20Socio-Cultural%20Challenges%20to%20Informed%20Consent%20in%20Nigeria.pdf> accessed 6 August 2021

44Ibid.

45 O Aniaka (n, 40)

while acknowledging the limitations of autonomy, particularly in life-threatening or complex medical situations. Autonomy, while foundational, must be balanced against other ethical principles—beneficence, non-maleficence, and justice—to ensure that patients are not only empowered to make decisions but are also protected from the potential harm of uninformed or impaired choices.

7.2 The evolving landscape of healthcare requires a refined approach to patient autonomy and informed consent, one that recognizes the value of patient empowerment without disregarding the professional obligation to safeguard health outcomes. As healthcare continues to grow in complexity, striking a balance between respecting the patient's autonomy and ensuring their well-being will remain a central challenge for medical ethics and law. This balance calls for a recalibration of the principles guiding informed consent, ensuring that patients are equipped with adequate information and support to exercise meaningful autonomy while protecting them from the risks inherent in medical decision-making. The future of healthcare ethics must continue to address these challenges, fostering a framework that respects patient rights while ensuring that clinical decisions promote optimal care outcomes.