

## DECISIONS MADE ON BEHALF OF THOSE WHO LACK CAPACITY (IN THE MEDICAL CONTEXT) UNDER THE ENGLISH AND NIGERIAN LEGAL SYSTEMS\*

### Abstract

*It is a fundamental principle of medical law and ethics that a medical practitioner should obtain the informed consent of a competent patient before treating such a patient. This is in tandem with the 'principle of autonomy' (self-determination) and best interests of a patient as gone are the days when 'a trust me, I'm a doctor' approach justified the imposition of treatment on a patient. Operating on a competent patient without obtaining her or his consent would amount to a contravention of a patient's right not to suffer torture or inhuman and degrading treatment. However, certain circumstances exist in the doctor-patient relationship wherein a patient lacks capacity to grant such consent to the medical professional – hence, the need for such consent to be given on her or his behalf in accordance to her or his best interests. This work therefore, considers how decisions made on behalf of those lacking capacity (in the medical context) under the English and Nigerian legal systems meet the needs of our contemporary societies with the aim of recommending the best practices for Nigeria as we strive to develop an efficient health care environment.*

**Key words:** *Decisions, Lack of Capacity, Medical Context, English Law, Nigerian Law*

### 1, Introduction

The question of decision making in relation to those who lack capacity presents a two-pronged challenge – preserving the right of the patient to personal autonomy while ensuring that she or he is dealt with in a manner that ensures his best interests or welfare.<sup>1</sup> Managing and reconciling these two phenomena – the patient's autonomy and welfare – are a very difficult task to handle due to the seeming indeterminate nature of the two.<sup>2</sup> In fact, such a task is bound to always prove delicate and tricky because the pursuit of one could mean negation of the other – for instance, insisting on the “welfare” of a child could mean intruding into his “autonomy” while insisting on his “autonomy” could mean risking his welfare. In addition to these two interests, there is also the public interest which is never to be overlooked in every organised society. Against the foregoing background, it may be persuasive to argue that in determining how decisions are made regarding those who lack capacity in the medical context may be best evaluated by bringing the above three interests to the fore – the autonomy of the patient, the welfare of the patient and the public interests.

### 2. The English Law Position

The general principle of law is that patients reserve the right to determine what treatment is to be administered to them.<sup>3</sup> Accordingly, in the case of *Chester v. Afshar*,<sup>4</sup> Lord Steyn posited 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 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.<sup>5</sup>

Again, the common law has long recognised the right to self-determination by every individual to wit: “the right of every person to have his or her bodily integrity protected against invasion by others.”<sup>6</sup> However, in the opinion of this writer, the first basic point to observe is that the English law (regarding

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<sup>1</sup> C P Selinger, ‘The Right to Consent: Is it Absolute?’ (2009) 2 *BJMP*, 50, 54

<sup>2</sup> *Ibid.*, p. 54

<sup>3</sup> J Herring, *Medical Law and Ethics* (4<sup>th</sup> Ed, Oxford University Press, 2012) p. 149

<sup>4</sup> [2004] UKHL 41, para 18

<sup>5</sup> See also the earlier case of *Schloendorff v. New York Hospital* [1914] 211 NY 125, 126

<sup>6</sup> J K Mason & G T Laurie, *Law and Medical Ethics* (9<sup>th</sup> Ed, Oxford University Press, 2013) pp. 70-71

decision making in relation to those who lack capacity) at its current stage of development is founded on the philosophy that a person who lacks capacity should have his right to autonomy but that at the same time this right should not be absolute. Selinger, while considering the issue of autonomy argues “that on a philosophical basis the principle of total autonomy contradicts itself when applied to society. As autonomy is the main ethical principle for informed consent an absolute right to consent cannot exist.”<sup>7</sup> Selinger further submits:

The debate whether a right or a principle is absolute not only involves ethical and legal aspects. It also touches on the philosophical argument of absoluteness. Freedom as an example can't exist as an absolute principle because granting one individual absolute freedom will infringe the freedom of a second individual considerably. Person A's freedom to take any good will influence the freedom of person B to have property. When applying these principles to autonomy the same problem arises: Total autonomy of one individual has a negative effect on autonomy of other individuals. The modern democratic society has designed rules and laws to create a fair way of living. On the one hand this restricts autonomy, while on the other hand this same restricted autonomy guarantees the same amount of it to all members of this society<sup>8</sup>.

Hence, recognising the need to preserve individual autonomy and yet without sacrificing other interests, the English law embraces the task of seeking an “acceptable balance” among all these interests. But the immediate difficulty confronting this task would be the potential fluidity and vagueness of the issues involved in decision making regarding those who lack capacity. For instance, Michael Gunn<sup>9</sup> aptly observes that:

Capacity/incapacity are not concepts with clear...boundaries. They appear on a continuum which ranges from full capacity at one end to full incapacity at the other end. There are, therefore, degrees of capacity. The challenge is to choose the right level to set as the gateway to decision-making and respect for persons...

This essay argues to the credit of the English legal system that the laws relating to this subject have – as a way of engaging this difficulty – adopted a strategy of constructing (defining) “lack of capacity” as a context-based category. This approach will potentially check extremity or absoluteness in adjudging one as lacking capacity in any given instance. Hence, the fact of “lacking capacity” has become both time and subject-specific. Time-specific in that a person cannot be declared incapable today just because he was found incapable yesterday<sup>10</sup>; and subject-specific in that a person cannot be declared incapable on one subject of medical decision-making just because he was found incapable on another subject.

Conversely, when a patient has, after taking due cognisance of all the contextual elements as required by the law, been declared as lacking capacity, a decision can be made on the person's behalf only in accordance with his “best interests”. Yet in line with its context-specific approach, the English law expects that in evaluating the patient's “best interests” wide assumptions should as best as possible be excluded; that the “specific circumstances” of the patient – and not the popular sentiment as to what is in a man's best interests<sup>11</sup> – should be considered.

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<sup>7</sup> *Op. Cit.* n. 1, p. 54

<sup>8</sup> *Op. Cit.* n. 1, p. 54

<sup>9</sup> British Medical Association, 'Ethical Kits for Students' (2011) <<http://bma.org.uk/practical-support-at-work/ethics/medical-students-ethics-tool-kit/consent-to-treatment-lacking-capacity>> accessed 4 January 2016

<sup>10</sup> The Mental Capacity Act, 2005, c. 9, s. 2(1) provides that “... a person lacks capacity in relation to a matter if at the *material time* he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain” (emphasis mine). Therefore, in concluding one as lacking capacity, what counts is the *material time* of decision making and not *time* in *absolute terms*.

<sup>11</sup> Medical Protection Society, 2013. Also, the Mental Capacity Act, 2005 provides that “Exactly what is in someone's best interests will depend upon his/her specific circumstances and is not confined to purely medical

The whole issue of autonomy in making decision regarding medical treatment is founded on the moral category – consent. In the US case of *Canterbury v Spence*<sup>12</sup> which introduced the doctrine of informed consent, the court held that:

The patient's right of self-decision shapes the boundaries of the duty to reveal. That right can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The scope of the physician's communications to the patient, then, must be measured by the patient's need, and that need is the information material to the decision.

The English law insists that a patient's consent must be an "informed consent" for his autonomy to be said to have been preserved.<sup>13</sup> Also, for consent to be valid, it must be shown that the patient has the capacity to consent and that the consent was given voluntarily having understood the nature of the treatment.<sup>14</sup> This, in the view of this writer, is still in line with the English law's strategy of contextualising "incapacity". By emphasising that one's consent must be "informed" the patient is treated as a distinct soul among all humans; circumstances specific to his cognitive space as an individual now become a key factor – educational background of the patient, his experience and general exposure in life are thus brought into the picture in determining his capacity for informed consent. Thus, "consent" – depending on how complex the involved medical issues are – may be understood differently when given by someone who has a medical background and when given by his counterpart without such a background.<sup>15</sup>

### Children

In regard to children, the *Mental Capacity Act*<sup>16</sup> is not the regulating law rather; the *Children Act*<sup>17</sup> as was aptly seen in the case of *B Local Authority v. RM*.<sup>18</sup> English law refuses to outrightly deny children the right to take decisions, but categorises children into two: those below 16 years and those of 16 and 17 years. This represents an attempt to achieve a compromise between the enduring tradition that adjudges all persons below 18 as children and the pragmatic consideration that at some point, drawing the line between childhood and adulthood could be an uncertain task. This, in the opinion of this writer, is commendable as it is another way of avoiding an absolute definition of "lacking capacity" in terms of age. However, the case of *Gillick v. West Norfolk and Wisbech Area Health Authority*<sup>19</sup> has been much more radical in this regard, as it has extended the potential for capacity even to children below the age of 16. This, arguably, may have struck some balance between the traditional age-based yardstick for measuring wisdom and the pragmatic approach which recognises that circumstances such as intellectual gift, level of exposure, family background and specific context of decision-making could enhance capacity irrespective of age. Similarly, the *Gillick* test may have made some allowance for variations in cognitive strength not uncommon among people of the same age group and for the fact that a child who may lack capacity in one instance may have capacity in another instance.

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considerations" and that "all factors, including religious beliefs or values expressed by the patient when competent be taken into consideration."

<sup>12</sup> [1972] 464 F (2nd) 772

<sup>13</sup> *Op. Cit. n. 1*, p. 54

<sup>14</sup> E Jackson, *Medical Law Text, Cases, and Materials*, (2<sup>nd</sup> Ed, Oxford University Press, 2006) p. 181

<sup>15</sup> From the same principle arises the fact that for consent to be valid, a doctor ought to provide the patient with all relevant information to be able to make a balanced judgment. But that the physician has provided this information will not in itself be enough, he ought to as well determine the patient's "ability to understand, retain, believe, evaluate, weigh and use information that is relevant to a medical intervention or its withdrawal". These tests are reflected in the Mental Capacity Act and have been affirmed by the courts in cases such as *Re MB (an adult: medical treatment)* [1997] 2 FLR 426, *Re C (adult refusal of treatment)* [1994] 1WLR 290, and *Re B (consent to treatment: capacity)* [2002] EWCH 429).

<sup>16</sup> 2005, c. 9

<sup>17</sup> 2004, c. 31

<sup>18</sup> [2010] EWHC 3802

<sup>19</sup> [1986] AC 112; [1985] 3 All ER 402

But given the special sensitivity of decision making in relation to children, the English law appears to be more cautious. It leaves too much powers neither in the hands of the child nor the parents, but seeks to achieve some balance by bringing in the courts. Hence: “if a child is not competent to consent, a proxy with parental responsibility can make decisions in the child’s best interests (these can however be overruled in court if they are decided not to be in the child’s best interests). The parents can consent to a treatment even if their child has refused. The courts can also consent on behalf of a child”.<sup>20</sup>

In the same vein, the potential risks in the powers given to children by *Gillick* test may have been counterbalanced by the practice of the court intervening in cases of refusal of life-saving treatment by children. In *Re W (a minor) (medical treatment)*<sup>21</sup>, the court overruled refusal of consent to treatment by a 16-year-old suffering from anorexia nervosa because such rejection of treatment poses significant risk of death or serious permanent injury. Such intervention, it is argued here, is a useful one in addressing the possibility of undue parental influence. Court decisions overruling joint child-parent refusal to consent to life saving blood transfusion as a result of the family religious faith<sup>22</sup> are well informed, as deciding otherwise would amount to holding that the current religion of the parents is necessarily the same religion the child would subscribe to when he becomes mentally mature to taking a personal religious stance. Such presumption may be akin to holding the child hostage in the religious den of his parents.

Thus, generally, it may be affirmed that in relation to children, the English law favours a system of checks and balances that shares the decision making powers between the child, the parent and the state (courts). This, in the opinion of this writer, is a helpful one.

### **Adults**

Another merit which this writer finds in the English law as it relates to the subject of this research is the requirement that “all adults have capacity unless it can be demonstrated otherwise, patients cannot be regarded as lacking capacity unless all practicable steps have been taken, without success, to help them come to a decision.”<sup>23</sup> This provision is pertinent because it proceeds from the principle that benefit of doubt should be given to a person before concluding him mentally incapacitated and consequently subjecting him to the “humiliation” of dragging him to a place he would never have loved to go. Besides, imputation of mental incapacity is a very sensitive thing whose impact on one’s reputation may not be easily salvaged in time. This echoes the criminal law principle of presuming someone innocent until proven guilty given that the cost of any mistake of judgment could be irremediable when the true fact becomes known. Admittedly, this approach is still in furtherance of the context-specific criterion of determining “lack of capacity” because giving every adult benefit of doubt means that every adult has the opportunity of having his specific circumstances closely examined before being declared as “lacking capacity”. In the context of criminal procedure, he is giving fair hearing before being pronounced “guilty”. More so, the English law allows individuals with capacity to make advance decisions to cover for any period wherein she or he becomes incapable to make decisions on her/his behalf. The writer finds the advance decision rule commendable save that it ought to include a provision for its alteration where it appears to be “harmful”.

Very significantly, the English law does not fail to keep the public interests in view in this whole question of preserving a patient’s autonomy. Though in many instances of this autonomy question, what is usually mostly at stake are apparently the rights of individuals, but in certain specific instances, the public interests become the most immediately and severely threatened of all interests. Examples are when a patient has a communicable disease or when a mentally ill person constitutes a threat of harm

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<sup>20</sup> UK Ministry of Ethics ‘Consent and Confidentiality’ <<http://ministryofethics.co.uk/?p=6>> accessed 24 December 2015

<sup>21</sup> [1992] 4 All ER 627

<sup>22</sup> *Op. Cit.* n. 19

<sup>23</sup> UK Medical Protection Society, 2014

to the community; and on these two the English law recognises the primacy of public interests over and above individual's interests<sup>24</sup>.

### 3. The Position of the Law in Nigeria

Under the Nigerian legal system, the framework for the regulation, development and management of a national health system and the setting of standards for rendering health services is the *National Health Act*<sup>25</sup>. Under the *Act*, there is no provision on how capacity is to be determined in relation to adults lacking capacity. However, *Part III* of the *Act* provides for the "rights and obligations of users and health care personnel. Its *Section 23* provides for the user to have full knowledge pertaining to his state of health and necessary treatment relating thereto.<sup>26</sup> The information should contain:

- (a) the user's health status except in circumstances where there is substantial evidence that the disclosure of the user's health status would be contrary to the best interests of the user;
- (b) the range of diagnostic procedures and treatment options generally available to the user;
- (c) the benefits, risks, costs and consequences generally associated with each option; and
- (d) the user's rights to refuse health services and explain the implications, risks, obligations of such refusal<sup>27</sup>.

This provision is in line with the protection and preservation of the autonomy of the patient over medical paternalism. More so, the combined effect of Sections 35, 37 and 38 of the Constitution of the Federal Republic of Nigeria<sup>28</sup> accord the Nigerian patient this right to autonomy. Thus, the Nigerian patient is therefore empowered to decide whether or not to submit to the line of treatment prescribed by the doctor for reasons which are rational or seemingly irrational or for no reason at all.<sup>29</sup> Consequently, in the case of *Medical and Dental Practitioners Disciplinary Tribunal v. Dr. John E.N. Okonkwo*, the Supreme Court of Nigeria held that a patient may validly refuse medical treatment or procedures recommended by the doctor and thus upheld the decision of the Court of Appeal that a doctor who observed the autonomy of the patient is not liable.<sup>30</sup> However, where the medical professional fails to honour the patient's right to refuse treatment, an action for assault and invasion of privacy may be validly instituted against the health care provider.<sup>31</sup>

Against the foregoing background, it is pertinent to state that the patient whose autonomy is to be observed must be of "full age" and capacity. "Full age" has been defined to mean "the age of eighteen years and above"<sup>32</sup>. Therefore, it could be inferred from the Constitutional provision that a person is presumed to have capacity once she or he becomes of full age (18 years and above).

### Children

In regards to decision making on behalf of a child under the Nigerian legal system, the best interests of that child shall be primarily considered. This is provided for in Article 4 (1) of the African Charter on the Rights and Welfare of a Child<sup>33</sup> which has been entrenched in the Child's Right Act to wit: "in every action concerning a child, whether undertaken by an individual, public or private body, institutions of service, court of law, or administrative or legislative authority, the best interests of the child shall be the

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<sup>24</sup> *Op. Cit.* n. 20

<sup>25</sup> 2014, SB. 215

<sup>26</sup> 2014, SB. 215

<sup>27</sup> 2014, SB. 215

<sup>28</sup> 1999 (as amended)

<sup>29</sup> A Toki, 'Patient's Right to Refuse Treatment in Nigeria', World Association for Medical Lawyers Newsletter\_Issue 27, 2015, pp.4-5

<sup>30</sup> *Ibid.*, p.4

<sup>31</sup> *Ibid.*, p.5

<sup>32</sup> CFRN, 1999 (as amended), s.29 (4) (a)

<sup>33</sup> ACRWC, July 1999

primary consideration”.<sup>34</sup> The *Children and Young Person’s Act* defines a “child” as a “person under the age of fourteen years” and a “young person” as a “person who has attained the age of fourteen years and is under the age of seventeen years”<sup>35</sup>. In light of these provisions, the quintessential question that is yet to be answered is: “what yardstick is in place to ensure that decisions made on behalf of children who lack capacity are made in their best interests?”.

Therefore, it becomes paramount to state that matters relating to children are in residuary legislative list and thus, depends on individual states<sup>36</sup>. While most states have adopted the *Child’s Right Act*<sup>37</sup>, some have changed the definition of “a child”. For some states, “a child” is “a young person under the age of thirteen years”<sup>38</sup>. For some others, the meaning is different – for example, in Akwa Ibom state, “a child” is a young person under the age of sixteen years<sup>39</sup>. In summary, the writer, in expressing discontent in relation to lack of a comprehensive definition of a child that is generally applicable to all states in Nigeria deems plausible the contentions of Iguh and Nosike to wit:

...the perception of age as a definition of a child in Nigeria depends on who is defining and varies according to cultural background. Furthermore, the lack of a comprehensive definition that is applicable throughout the nation, is an all-encompassing handicap with regard to the just application of the provisions of the law<sup>40</sup>.

#### 4. Conclusion and Recommendations

In summary, it is restated that the issues involved in dealing with the autonomy of persons who lack (or suspected of lacking) capacity are very sensitive, fluid and at times indeterminately vague; and that by precluding absoluteness in determining these issues, the English law is fairly well positioned to satisfy the need of the present society. This character of the English law is succinctly captured by the British Medical Association<sup>41</sup> wherein it was stated that “there is no straightforward answer in determining when a person lacks capacity.” In addition, by involving the court (particularly in relation to children), the English law has commendably instituted external checks against abuses. And by ensuring that outright removal of an individual’s autonomy is done only when the interest of the public is mostly at stake – such as with communicable diseases – the law has drawn the line just at the perfect spot.

However, it must be admitted that the English law cannot answer all the questions arising from the issue of the autonomy of patients who lack decision-making capacity. Despite all the merits pointed out above, it is still the case that, like in all matters regarding human rights and public interests, there is much room for subjectivity in the interpretation of letters of the law. For instance, David Hunter and Barbara Pierscionek<sup>42</sup> observe that “A *Gillick* rightly competent child can give consent to medical procedures as an autonomous adult. The subjectivity of the concept arises because the law leaves the decision about whether a child is *Gillick* competent to the individual practitioner.” Against this backdrop, the writer suggests that as a way of reducing the impact of subjectivity in the process of implementing the present law, relevant regulatory bodies should optimise the practice of producing guidelines in the form of practice manual to break down the provisions of the law into categorical, unambiguous specifics. These guidelines should also be continuously updated relying on new insights coming from everyday field experience of practitioners and other concerned persons.

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<sup>34</sup> Child’s Right Act, Cap 2003

<sup>35</sup> s.2, Cap. 22, Laws of the Federation of Nigeria, 2004

<sup>36</sup> N A Iguh, & O Nosike, ‘An Examination of the Child Rights Protection and Corporal Punishment in Nigeria’ (2011) Nnamdi Azikiwe University Journal of International Law and Jurisprudence, volume 2, p. 108

<sup>37</sup> *Ibid.*, p. 108 – Some of the states are Anambra, Abia, Bayelsa, Rivers, Ebonyi, Edo, Ekiti, Imo Jigawa, Kwara Lagos, Nassarawa, Ogun, Ondo, Taraba, etc.

<sup>38</sup> *Ibid.*, p. 108

<sup>39</sup> *Ibid.*, p.108

<sup>40</sup> *Ibid.*, p.108

<sup>41</sup> British Medical Association, *Op. Cit.* n.9

<sup>42</sup> D Hunter & B K Pierscionek, ‘Children, Gillick Competency and Consent for Involvement in Research’ (2007) 33 J Med Ethics 659, 662

Contrasting the situation in Nigeria with what the situation is in the UK, one is compelled to admit that such an elaborate legal and institutional framework for determining who lacks capacity appears to be at its emerging stage still and thus plagued with inconsistencies. In other words, for whatever its shortcomings might be, the British system still presents a compelling model for a case study for Nigeria as she searches for her own domestic structure. As rightly observed by Irehobhude Iyioha, “health law and policy in Nigeria is a novel field. ‘Novel’ in this context implies evolving and uncharted.”<sup>43</sup> Furthermore, much of the existing health law in the country is imported from Britain, her erstwhile colonial masters; albeit this might not exactly reflect the domestic cultural and political realities.<sup>44</sup>

In the light of the above, there is need for Nigeria to enact an Act that would be of general application to provide for the determination of capacity and to define who a child is. The English legal system, where appropriate should be adopted to develop our laws in Nigeria as most of our laws were adopted from Britain – our erstwhile colonial masters. Patients’ right to autonomy should stand supreme and must be observed in any doctor/patient relationship in Nigeria except where it is impracticable. Medical professionals should be enlightened on the position of the law in regards to “informed consent” in order to engender good practices in the doctor/patient relationship. A module should be introduced in the undergraduate programmes in the Nigerian universities to enlighten medical professionals on patients’ rights. Different medical association bodies in Nigeria should provide medical practitioners with an up to date code of conduct/good medical standards to be adopted by every medical practitioner and a monitoring task force should be established to ensure compliance.

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<sup>43</sup> I O Iyioha, ‘Pathologies, Transplants and Indigenous Norms: An Introduction to Nigerian Health Law and Policy’ (2015)

<sup>44</sup> *Ibid.*