

## THE LEGAL BASIS FOR DETERMINING PATIENTS' DECISION-MAKING CAPACITY IN MEDICAL PRACTICE IN NIGERIA

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### Abstract

A critical element pertaining to patient's autonomy and decision-making in clinical contexts is capacity to make decision. This refers to the ability of a patient to understand his or her medical condition and the available medical options as well as the ability to decide and communicate such choice to the medical authorities or the concerned health institution. Decision-making capacity in practical terms may not be as straightforward as it might seem. Its intricacies become obvious once close attention is paid to the details of its practical implementation and the problems associated thereto. Apparently, the foremost of such intricacies is the potential fluidity and vagueness regarding adjudging a patient to have capacity or lack thereof. This study adopted the doctrinal method of research. The study, through its inter-jurisdictional comparison, found that Nigeria is still lagging behind in terms of statutory and case laws in this aspect of her legal system. The study recommended that the Mental Health Bill in line with the articulated terms of the National Policy Document for Mental Health Services Delivery in Nigeria be passed into law.

**Keywords: Patients, Capacity, Incapacity, Decision-Making, Mental Health.**

### 1. Introduction

It is the fundamental principle of medical ethics today that it is the patient who calls the shot in every doctor-patient relationship as gone are the days when "a trust me, I am a doctor approach" guided such relationship. Accordingly, decision-making is an intrinsic right possessed by every competently adjudged patient, hence an inextricable right. However, circumstances abound where a patient can be adjudged incapable of making decision for his/herself. In such an instance, a decision is made on his/her behalf albeit such decision made for the incapable patient must be made in the patient's best interests.

For instance, Michael Gunn<sup>1</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...

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<sup>1</sup> British Medical Association, 'Ethical Kits for Students' (2011) p. 9 <<http://bma.org.uk/practical-support-at-work/ethics/medical-students-ethics-tool-kit/consent-to-treatment-lacking-capacity>> accessed 4 January 2019.

This study examines decision-making capacity from the perspective of the Nigerian law and comparing it with what obtains in some other jurisdictions.

## 2. Lack of Capacity under the Nigerian Law

According to the Black's Law Dictionary, "capacity" is:

the power to create or enter into a legal relation under the same circumstances in which a normal person would have the power to create or enter into such a relation; specifically, the satisfaction of a legal qualification, such as legal age or soundness of mind, that determines one's ability to sue or be sued, to enter into a binding contract, and the like.<sup>2</sup>

Capacity in the medical context refers to a situation where a patient is competent to personally make a choice either to accept or reject a proposed treatment. For a person to be adjudged to have capacity to consent to a proposed medical treatment, he or she must be in good mental and or physical state and must be an adult (or *Gillick* competent<sup>3</sup> in cases involving a child/minor). Hence, people typically considered to lack capacity include people in an unconscious state, children and mentally ill persons. The Nigerian Supreme Court has upheld the right of an adult patient to consent to or refuse a particular type of treatment in the case of *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo*.<sup>4</sup> The Court hinged this right on the constitutional rights to privacy, freedom of thought, conscience and religion. Specifically, the Court held that 'the right to privacy implies the right to protect one's thought, conscience and religious belief and practice from coercive and unjustified intrusion; and one's body from unauthorised invasion'.<sup>5</sup> The case not only upheld the right of an adult competent patient to consent to or refuse treatment, it also absolved from liability, a service provider who has exercised the duty of care to advise and inform the patient of the risks involved in the refusal to give consent.<sup>6</sup>

Across various jurisdictions, lack of capacity in clinical settings is ideally determined by appealing to statutory provisions and case laws. In Nigeria, this ought to be the case given that the nation's legal system – following the Common Law tradition – is basically rooted in statutes and judicial precedents. Hence, in assessing lack of capacity under the Nigerian jurisdiction, attention should ideally be paid to statutes and court decisions in

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<sup>2</sup> B A Garner, *Black's Law Dictionary*, (8<sup>th</sup> Edn. St. Paul M N USA, 2004) p. 220.

<sup>3</sup> To be explained later in this study.

<sup>4</sup> [2001] 7 NWLR (Part 711) 260. See also *Augustine Nwofor Mojekwu v Caroline Mojekwu* [1997] 7 NWLR pt 512 at 532.

<sup>5</sup> N I Aniekwu, 'Protecting Reproductive Health and Rights in Domiciliary Law: Recommendations and Strategies for Nigeria' *NIALS Journal of Health Law and Policy*, (Maiden Edn), p. 103.

<sup>6</sup> *Ibid.*, pp. 103-104.

this regard. The existence and adequacy of such statutory provisions and case laws will help in taking a stance as to the strengths and weaknesses of the legal system vis-à-vis lack of capacity. To more effectively undertake this task, this assessment is carried out under a number of subheads representing the various occasions of incapacity as presented below.

### **2.1. Age of the Patient**

Incidentally, the only mention of lack of capacity in relation to a minor in the National Health Act<sup>7</sup> is in the area of consent for disclosure of a patient's health information. Thus, it is prohibited for any person to disclose the health information of a minor unless upon the request of a parent or guardian.<sup>8</sup> In other words, a minor is recognised as lacking capacity to give such consent regarding his/her health information, hence the decision is left in the hands of a parent or guardian. However, no definition of a minor is given in the Act, suggesting that a minor may be taken to mean a person below the age of 18 as defined in the Child's Rights Act.<sup>9</sup> Against this background, a question may be raised as to the propriety of this blanket definition as will be seen later in this chapter in making comparison with what obtains in other jurisdictions.

Nonetheless, the age factor in decision-making also features in the Child's Rights Act, 2003. Interestingly, the very first provision of the Act reads:

In every action concerning a child, whether undertaken by an individual, public or private body, institutions or service, Court of law, or administrative or legislative authority, the best interest of the child shall be the primary consideration.<sup>10</sup>

This provision is adopted from Article 4 (1) of the African Charter on the Rights and Welfare of a Child.<sup>11</sup> Implicit in the foregoing provision is the recognition that a minor is characteristically vulnerable and often relies on help of others for protection of his/her interests. This vulnerability will also include incapacity to make decision, which leaves the minor requiring from time to time, the intervention of other persons to decide for him/her. Thus, the fact that this provision comes before every other provision in the Act, points to its importance in the mind of the draftsman.

The Child's Rights Act<sup>12</sup> significantly provides that a minor is entitled to all the fundamental rights as enshrined in Chapter IV of the Constitution of the Federal Republic

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<sup>7</sup> Act No. 8, FRN Official Gazette, 2014.

<sup>8</sup> S.26 (2) (b) (i).

<sup>9</sup> CRA, 2003 Cap. C50 LFN, 2004, s.277.

<sup>10</sup> CRA, Cap. C50, LFN, 2004, S.1.

<sup>11</sup> ACRWC, OAU DOC. CAB/LEG/24.9./49 1999.

<sup>12</sup> CRA, Cap. C50, LFN, 2004.

of Nigeria, 1999 as amended<sup>13</sup> and any subsequent constitutional provisions relating to fundamental rights.<sup>14</sup> In addition to this, the Act specifically mentions that a minor is entitled to the right to freedom of thought, conscience and religion.<sup>15</sup> Incidentally, this right has been a recurring basis for decision-making consideration as also seen in what has become a landmark case in Nigeria – *Medical and Dental Practitioners Disciplinary Tribunal v Dr. Okonkwo*.<sup>16</sup> Here, the appellant, Dr Okonkwo, was found guilty of professional misconduct by the Medical and Dental Practitioners Disciplinary Tribunal. He had honoured the verbal and written wishes of a Jehovah’s Witness patient who refused blood transfusion and consequently died during treatment in another hospital. The appellate Court upheld Dr Okonkwo’s appeal and the Supreme Court concurred.<sup>17</sup> The apex Court ruled that an adult Nigerian has a right to refuse life prolonging medical treatment, including blood transfusion. The Court located that right in the constitutional right to privacy and freedom of thought, conscience and religion. The Court, in defining the limits of treatment in that judgment, stated:

The patient’s consent is paramount . . . [Accordingly] the patient’s relationship [with the Doctor] 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.<sup>18</sup>

However, while the *Okonkwo’s case* made news within the Nigerian medical community because it was the first of its kind, its full impact on informed consent among physicians was not realized because it was perceived by many of them as a case of the right of Jehovah’s Witnesses to refuse blood transfusion. This decision, however, threw more light on the expectations in the patient-physician relationship in Nigeria and points to the likely course legal rulings will take if and when litigations become a major part of the significant forces shaping consent practices in Nigeria.

However, in relation to a child, there is a further provision requiring that parents or legal guardians ‘shall provide guidance and direction in the exercise of these rights having regard to the evolving capacities and best interest of the child’<sup>19</sup> and that the ‘duty of parents and, where applicable, legal guardians to provide guidance and direction in the enjoyment of such right... by their child or ward shall be respected by all persons, bodies,

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<sup>13</sup> 1999.

<sup>14</sup> S.3, CRA, Cap. C50, LFN, 2004.

<sup>15</sup> S. 7(1), CRA, Cap. C50, LFN, 2004.

<sup>16</sup> (2001) 7 NWLR (Part 711) 206.

<sup>17</sup> [2001] 4 SCN 78. NWLR, Part 711: 205–255.

<sup>18</sup> *Medical and Dental Disciplinary Tribunal v. Okonkwo* [2001] 4 SCN 78. NWLR, Part 711: 205–255.

<sup>19</sup> CRA, Cap C50, LFN, 2004, S. 7(2).

institutions and authorities'.<sup>20</sup> The implication of the foregoing is that once a minor is considered to lack decision-making capacity in a circumstance involving religious conviction, the parent or guardian has the overriding power and responsibility to step in. However, this right is not to be observed in situation where it amounts to an enslavement of the child patient into the religious den of his/her parent.<sup>21</sup>

Similarly, the Act provides for the right to privacy of a child.<sup>22</sup> This right constitutes the basis for obtaining a patient's consent for certain treatments such as surgical operation as doing otherwise might give rise to an action for trespass to person. However, this right is still subject to 'the rights of parents and, where applicable, legal guardians, to exercise reasonable supervision and control over the conduct of their children and wards.'<sup>23</sup> The implication of this is that the minor's 'incapacity' is assumed here – hence the right of the parent or guardian to intervene.

The Child's Rights Act, nonetheless, requires that the consent of a minor be obtained before a scientific sample is taken from him/her for purposes of determining paternity or maternity.<sup>24</sup> The provision goes further:

The consent of a child who has attained the age of sixteen years to the taking from himself of a scientific sample shall be as effective as it would be if he had attained the age of majority and where a child has by virtue of this subsection given an effective consent to the taking of scientific sample, it shall not be necessary to obtain any consent for it from any other person.<sup>25</sup>

But where the minor has not attained the age of 16, the consent of the person who has the care and control of the child is required for such sample to be taken.<sup>26</sup> However, in a situation where the minor is suffering from mental disorder within the meaning of any relevant law in Nigeria and is incapable of understanding the nature and purpose of the scientific tests, then such sample may be taken only with the consent of the person who has the care and control of the child as well as the certification of the medical practitioner taking care of the child that the taking of the scientific sample shall not be prejudicial to the child's proper care and treatment.<sup>27</sup> So, for the purpose of taking scientific sample, one is considered incapable if they are still below the age of 16. Mental disorder will, however, interfere with this rule – albeit if the disorder is such that hampers understanding of the nature and purpose of the scientific tests.

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<sup>20</sup> CRA, Cap C50, LFN, 2004, S. 7(3).

<sup>21</sup> See the case of *Esabunor v Faweya op. cit.*

<sup>22</sup> *Ibid.*, CRA, Cap C50, LFN, 2004, S.8.

<sup>23</sup> *Ibid.*, CRA, Cap C50, LFN, 2004, S.8 (3).

<sup>24</sup> *Ibid.*, CRA, Cap C50, LFN, 2004, S.64(1).

<sup>25</sup> *Ibid.*, CRA, Cap C50, LFN, 2004, S.64.

<sup>26</sup> *Ibid.*, CRA, Cap C50, LFN, 2004, S.64(3).

<sup>27</sup> *Ibid.*, CRA, Cap C50, LFN, 2004, S.64(4).

Regarding the order of a Court that a child *subjects* him/herself to psychiatric or medical examination, the Act bars the Court from issuing such order if “the child has sufficient understanding to make an informed decision” unless such a child consents to such examination.<sup>28</sup> Similarly, the Act bars the Court from issuing an order *compelling* a minor to submit to psychiatric or medical treatment if “the child has sufficient understanding to make an informed decision” unless such a child consents to such examination.<sup>29</sup> However, the Act is more explicit in *Section 42* which concerns emergency order of the Court for protection of a child in danger of harm. It provides that such order may include subjecting the child to medical or psychiatric examination, but that where such order is given, ‘the child may, if he has sufficient understanding to make an informed decision, refuse to submit to the examination or other assessment’.<sup>30</sup> A clear problem here is determining what exactly will constitute ‘sufficient understanding’. What is the test or criterion for establishing such? Unfortunately, there appears not to have been any case law to shed light on this potentially difficult concept.

One seeming problem with age as a factor in decision-making capacity in Nigeria is lack of uniform definition of who is a child. The *Child’s Rights Act* defines a child as a person below the age of 18 years.<sup>31</sup> Also, matters relating to children are in the residuary legislative list under the Constitution and thus legislations on child-related matters are within the jurisdiction of individual States, though not exclusively.<sup>32</sup> While most States have adopted the *Child’s Right Act*,<sup>33</sup> some have not. Thus, the definition of “a child” in some cases differ from State to State. For some states, “a child” is “a young person under the age of thirteen years”.<sup>34</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>35</sup> In Anambra state, “a child” means, a person under the age of eighteen years.<sup>36</sup> Thus, as stated by Iguh and Nosike:

...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

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<sup>28</sup> *Ibid.*, CRA, Cap C50, LFN, 2004, S.4(3) (a).

<sup>29</sup> *Ibid.*, CRA, Cap C50, LFN, 2004, S.5(5) (a).

<sup>30</sup> *Ibid.*, CRA, Cap C50, LFN, 2004, S.42 (6).

<sup>31</sup> CRA, Cap. C50, LFN, 2004, S. 277.

<sup>32</sup> N A Iguh and O Nosike, ‘An Examination of the Child Rights Protection and Corporal Punishment in Nigeria’ [2011] (2) *Nnamdi Azikiwe University Journal of International Law and Jurisprudence*; p. 108.

<sup>33</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>34</sup> *Ibid.*, p. 108.

<sup>35</sup> *Ibid.*, p.108.

<sup>36</sup> Child’s Right Law, 2004, Gazette 05 Awka.

applicable throughout the nation, is an all encompassing handicap with regard to the just application of the provisions of the law.<sup>37</sup>

Thus, this lack of uniformity among the sub-jurisdictions that make up Nigeria regarding who is a child will arguably constitute some conceptual and practical difficulties in dealing with issues of decision-making and lack of capacity thereof. More significantly, the fact that the above highlighted standards found in the Child's Rights Act, may on that basis, not be a holistic representation of what obtains in the country.

However, a unifying element may be the Code of Medical Ethics in Nigeria,<sup>38</sup> a subsidiary legislation of the Medical and Dental Practitioners Act of Nigeria<sup>39</sup> (MDCN) that regulates the affairs of the Medical and Dental Council of Nigeria (MDCN). With reference to decision-making where a minor is involved, Rule 19, Part A of the Code of Medical Ethics in Nigeria,<sup>40</sup> states:

Where the patient is under aged, (below eighteen years (18) by Nigerian law)... a next-of-kin should stand in. In the absence of a next-of-kin, the most senior doctor in the institution can give appropriate directive to preserve life. In special situations, a Court order may need to be procured to enable life-saving procedures be carried out.<sup>41</sup>

Since this Code applies to all medical practitioners in Nigeria irrespective of State of practice, the above may be a unifying standard – at least within the profession. But it remains to be seen whether a decision taken based on this subsidiary legislation will stand when challenged in Court based on a differing definition of a child in the law of the State in which the decision was taken. Incidentally, the Code, in a later provision, takes a more flexible position:

Those within the ages of 16 to 18 years have a statutory right of their own to consent to procedures and this takes precedence over parental objections, but does not invalidate the right of others to consent on their behalf. However, where the child of this age group objects and parental consent is obtained in an emergency situation, appropriate treatment or procedure can be given. Children younger than 16 but not below 13, though considered as minors, but of clear mind and can grasp the benefits and consequences of accepting or rejecting a proposed treatment, "Gillick-competence", can give an acceptable consent in respect of children under 13 but the well-

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<sup>37</sup> *Ibid.*, p.108.

<sup>38</sup> CMEN, 2004.

<sup>39</sup> CAP M8, Laws of the Federation of Nigeria, 2004.

<sup>40</sup> CMEN, 2004.

<sup>41</sup> CMEN, 2004.

being of the child is paramount and if after full parental consultation, treatment is refused, the practitioner should make use of the law by obtaining an order from the Court to protect the child's health interest. A child who needs blood transfusion or procedures in any emergency should be so given. A practitioner who stands by and allows his minor patient to die in circumstances which might be avoidable may be charged with negligence and is also vulnerable to criminal prosecution.<sup>42</sup>

The above clearly shows the adoption of the standard maintained in the British jurisdiction. The Code's use of the term 'Gillick-competence' unmistakably points to this fact. Obviously, no legislation or case law has established such detailed principles for determining a child's lack of capacity in Nigeria, a situation that must have prompted the Medical and Dental Council of Nigeria (MDCN) to borrow the British standard. This seeming *lacuna* in the Nigerian law, as noted in Chapter One, is an important motivation for this study. Again, the Child's Rights Act does not recognise decision-making capacity on the part of children below the age of 16 as does the "Gillick-competence" test adopted by the MDCN Code, meaning that there might be a conflict between the Code and the Act, and the former being a subsidiary legislation, the latter will prevail once such conflict is established. This seems to suggest that some streamlining is still required in the Nigerian jurisprudence with regard to decision-making involving minors.

## 2.2. State of Unconsciousness

Being in a state of unconsciousness is a common factor giving rise to consideration of lack of capacity and the observance of patients' right to autonomy in the medical sphere. Patients often are brought to hospitals in an unconscious state or fall into such a state after having arrived in a conscious state. Such occasion usually calls for urgent intervention to save the life of the patient, which all the more makes decision-making potentially more problematic. Discussing state of unconsciousness as a decision-making factor in Nigeria, Gbobo and Oke-Chinda observe that:

An unconscious patient has no capacity to give consent but it is presumed that if he were capable of giving such consent, he will do so to save his/her life. In this circumstance, the Doctrine of Necessity will apply. In criminal and civil law, the doctrine of necessity gives legitimacy to an otherwise wrong act but the intention is of paramount importance, which is – to save or preserve a human life. Therefore, a physician who carries out a procedure or treatment on an unconscious patient to save his/her life should not

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<sup>42</sup> CMEN, Rule 39 (b) (c).

incur criminal liability; hence necessity is a defence for non-consensual treatment especially in an unconscious patient.<sup>43</sup>

This doctrine of necessity appears implicit in the Code of Medical Ethics in Nigeria. The Code states:

Where the patient... is unconscious, or is in a state of mind constituting a mental impairment, a next-of-kin should stand in. In the absence of a next-of-kin, the most senior doctor in the institution can give appropriate directive to preserve life. In special situations, a Court order may need to be procured to enable life-saving procedures be carried out.<sup>44</sup>

But what may constitute the 'special situations' in which a Court order may be required to proceed with life-saving procedures? This is not provided for in the Code. However, it may include a situation where there is no risk of the patient dying so soon as to consider his/her situation an emergency that should be attended to without delay.

The same doctrine of necessity is again clear in the Code's provision regarding unconscious patients who may have objection to certain forms of treatment on grounds of religion. It states:

It is uncommon for some religious sects to carry cards (advance directives) containing treatment instructions. The practitioner should be meticulous in receiving unconscious religious adherents. Their clothings should be searched for such cards. Even if accompanying relatives present such cards, clinicians should convince themselves that such cards truly belong to the patient before them. In the absence of such cards, the priority of the practitioner in an emergency situation is to save life first. If long intervention is envisaged, a court permit for continuous management should be obtained.<sup>45</sup>

In the above provision, determining when a Court order is required may not be as difficult. It is clearly needed when treatment will be a prolonged one. Thus, such order intervenes to either sanction the continuation or end such treatment. Similarly, while not specifically mentioning state of unconsciousness, the National Health Act<sup>46</sup> explicitly permits waiving of consent before removal of tissue, blood or blood product from a

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<sup>43</sup> P I Gbobo, & M Oke-Chinda 'An Analysis of the Doctrine of Informed Consent in Nigeria's Health Care Services' [2018] (69) *Journal of Law, Policy and Globalization*; p. 15.

<sup>44</sup> Rule 19, Code of Medical Ethics in Nigeria, 2004.

<sup>45</sup> Rule 39 (d), Code of Medical Ethics in Nigeria, 2004.

<sup>46</sup> Act No. 8, FRN Official Gazette, 2014.

patient's body if the purpose is for "medical investigation and treatment in emergency cases".<sup>47</sup> In other words, the "doctrine of necessity" becomes activated.

The doctrine of necessity is demonstrated in *Marshall v Curry*<sup>48</sup> where the plaintiff sought for damages for battery against a surgeon who removed one of his testicles in a surgery of hernia. The surgeon claimed that the testicle was diseased and would affect the life of the patient if not removed immediately. The Court held that the action of the surgeon was necessary at the point. However, in *Murray v McMurdy*,<sup>49</sup> the action of battery succeeded where the surgeon sterilized a female patient by removing her uterus without her consent during a caesarian section operation. The Court held that the procedure of sterilization is not detrimental to the life of the patient and could be decided later. Thus, there ought to be a life-threatening urgency for such waiving of consent to be legal. Gbobo and Oke-Chinda made this point when they observed that "a physician should not take undue advantage of the unconscious state of a patient to carry out a procedure more extensive than what is immediately required to save the life of the patient".<sup>50</sup> Apparently, there is no case law establishing such principle within the Nigerian jurisdiction.

### 2.3. Infirmity of the Mind

Infirmity of mind represents an important consideration in the sphere of patients' right to autonomy, decision-making and lack of capacity thereof. Unfortunately, mental health has failed to receive the required attention in health policy making and implementation in the country,<sup>51</sup> and this appears to have also affected the legal aspect of mental health. Oyewole tries to capture this national *lacuna*:

Psychiatry itself is primarily a biological science with potent social correlations. By implication, the care of the mentally ill presents many complex social issues that require robust legal instrumentation that will protect the patient, guarantee that the powers of the psychiatrist are not abused and that the community is also protected from danger that may occur when the patients are not treated. Mental health legislation therefore balances complex, and sometimes, opposed interests. Human right activists often allege that psychiatric patients are sometimes deprived of their basic rights; certainly the history of psychiatry has been marred by some abuse of power but contemporary and modern psychiatry has recognised the extensive nature of the powers accorded it and seeks to exercise them cautiously. Although these issues are of paramount

<sup>47</sup> NHA, Act No. 8, FRN Official Gazette, 2014, S. 48(b).

<sup>48</sup> (1933) 3 DLR 260.

<sup>49</sup> (1949) 2 DLR 442.

<sup>50</sup> P I Gbobo, & M Oke-Chinda *op cit.*, p. 18.

<sup>51</sup> L Audu 'Mental Health and Policies in Nigeria' [2016] (4) *Nigeria Journal of Social Work*; p. 891.

importance where they have ideal psychiatric practice with well-established mental health care delivery system; we all agree that the scenario in Nigeria is quite different and that is putting it mildly.<sup>52</sup>

Not surprisingly, the only legislation dedicated to mental health in the country is still a piece of colonial legacy – the Lunacy Act of 1958<sup>53</sup> – which has been severally criticised for what is seen as its obsolescence and failure to make key provisions required for efficient and satisfactory administration of mental health in line with the global best practices.<sup>54</sup> Commenting on the law, Oyewole who describes it as the ‘only available mental health care document in Nigeria’ fails to make provisions for relevant “issues of mental health care like compulsory intervention, consent to treatment, protection of patient’s rights, and restriction of certain forms of treatment”. Similarly, Adewuya agrees that the shortcomings in the Lunacy Act include defective definition of mental health issues which are ‘far from the WHO’s definition/description of mental health issues’. Also among the shortcomings is the fact that ‘the Act leaves too much discretion to medical practitioners and magistrates to determine who a “lunatic” is and whether treatment should be given or not’. There is also “no provision for patients’ consent, nor opportunity for the person to contest or appeal against the detention”.<sup>55</sup>

It is against this backdrop that the Chief Judge of Lagos State, Justice Oluwafunmilayo Atilade, has called for urgent and comprehensive review of the Lunacy Act of 1958<sup>56</sup> to bring it up to date with global standards. While arguing that the law remains ‘grossly inadequate’, she states:

Presently, the Lunacy Act of 1958 requires a comprehensive makeover, not simply to get rid of the cobwebs or shed the toga of an antiquated legislation but to truly address what is a most serious issue underlying most dysfunctional behaviour in our society which due to our misunderstanding received the wrong or poor attention.<sup>57</sup>

Quite positively however, the Federal Ministry of Health Abuja, Nigeria has prepared a National Policy Document for Mental Health Services Delivery in August, 2013 wherein issues pertaining to mental patients were captured. This is a step in the right direction. However, it remains only but a policy document and at best, serves as a brochure/directive for handling such patients. Thus, when confronted with any

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<sup>52</sup> O Adeoye ‘Nigeria and its ‘Archaic’ Mental Health Legislation’ (2017) *The Punch*.

<<https://punchng.com/nigeria-and-its-archaic-mental-health-legislation/>> accessed 24 February 2019.

<sup>53</sup> Cap. 112.

<sup>54</sup> A Onanuga ‘Wanted: New Lunacy Law’ (2016) *The Nation*.

<http://www.thenationonline.net/wanted-new-lunacy-law/>> Accessed February 24 2019.

<sup>55</sup> *Ibid.*

<sup>56</sup> Cap. 112.

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

contradictory provision of the Lunacy Act of 1958 (though moribund), the later, being a national legislation, will prevail. Hence the need to pass into law the Mental Health Bill in line with the articulated terms of the National Policy Document for Mental Health Services Delivery in Nigeria.

The implication of the foregoing is that issues of decision-making and lack of capacity remain largely unresolved in Nigeria in the legal sense. It is for this reason that the Mental Health Bill was introduced in the National Assembly in 2003 as sponsored by Sen. Ibiabuye Martyns-Yellowe and Sen. Dalhatu Tafida. On March 20, 2013, the Bill was re-introduced to the National Assembly by Hon. Samuel Babatunde Adejare and Hon. Solomon Olamilekan Adeola after having been withdrawn in 2009.<sup>58</sup> Though the Bill is yet to be passed since then, some of its provisions show clearly that it intends to fill the gaps left by the Lunacy Act including the area of consent and decision-making.

Regarding treatment, the Bill proposes that no form of treatment can be given to a person with mental infirmity unless the responsible medical officer certifies in writing that:

the patient is capable of understanding the nature, purpose and likely effects of the treatment and thus consented to it; or the medical officer ... certifies in writing that the patient has not consented to the treatment for reason of incapacitation... but that having regard to the likelihood of its alleviating or preventing a deterioration of his condition, the treatment should be given.<sup>59</sup>

Stated differently, where the patient is considered incapable of making decision, the medical officer may proceed with the treatment if it is considered critical to improving or preventing deterioration of the patient's condition. A patient may, at any time before the completion of treatment for which he had previously given consent, withdraw such consent in writing.<sup>60</sup> Nevertheless, the Bill provides that no such consent of the patient is required in the following circumstances:

- i. When the treatment is required to immediately save the patient's life;
- ii. When the treatment (which not being irreversible) is immediately necessary to prevent a deterioration of his/her condition; or
- iii. When the treatment (which not being irreversible or hazardous) is immediately necessary to alleviate serious suffering by the patient; or
- iv. When the treatment (which not being irreversible or hazardous) is immediately necessary and represents the minimum interference necessary to prevent the patient from violence or being a danger to himself or to others<sup>61</sup>.

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<sup>58</sup> A Onanuga, *op cit*.

<sup>59</sup> MHB, S. 27.

<sup>60</sup> MHB, S. 27(4).

<sup>61</sup> MHB, S. 27 (5).

The implication of the foregoing is that the patient's capacity is immaterial here as the treatment will go on irrespective of his/her desire. Apparently, the medical expert will be guided solely by the doctrine of necessity. The Bill also requires a medical officer responsible for a mental patient to in all circumstances 'take into account the condition of the patient, the need to obtain consent from the nearest relative, periods of lucid intervals and his/her personal moral decision to obtain consent'.<sup>62</sup>

In the final analysis, the fact that this document is still at the level of a bill means that the nation has made no real progress from the deficiencies of the Lunacy Act of 1958. For now, it would appear that the Code of Medical Ethics in Nigeria remains the only legal document that seeks to address the issue of decision-making in the context of mental infirmity. It reads:

Where the patient... is in a state of mind constituting a mental impairment, a next-of-kin should stand in. In the absence of a next-of-kin, the most senior doctor in the institution can give appropriate directive to preserve life. In special situations, a Court order may need to be procured to enable life-saving procedures be carried out.<sup>63</sup>

Admittedly, the above will be inadequate for dealing with all the complex questions raised by mental health in the area of decision-making by patients. The nation requires an elaborate legal framework to address the existing loopholes.

#### **2.4. Illiteracy**

Another important factor to be considered in the observance of patients' right to autonomy in the doctor-patient relationship is the issue of illiteracy. This is because certain information required by a patient to make a decision might be given in writing. But more importantly, the patient, in cases such as surgical treatment, is expected to give his/her consent in writing by filling the appropriate form. Inability to read and write will be a serious obstacle to the performance of this activity. Again, there is the problem of inability to comprehend the nature of the proposed medical procedure especially in the face of complicated technology.

In Nigeria, there may still be need for statutory provisions specifically dealing with documents and writings relating to decision-making in a clinical setting. This will help deal with the peculiarities of such occasions. The National Health Act,<sup>64</sup> for instance, attempts to do this in its provision relating to the health practitioners' duty to inform the patient of their health status, range of diagnostic procedures, treatment options,

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<sup>62</sup> MHB, S. 27 (6).

<sup>63</sup> CMEN, 2004, Rule 19.

<sup>64</sup> NHA, Act No. 8, FRN Official Gazette, 2014.

benefits/risks thereof, and their right to refuse treatment. The Act states: ‘The health care provider concerned shall, where possible, inform the user in a language the user understands and in a manner which takes into account the user’s level of literacy’.<sup>65</sup> This will imply that where such patient cannot read, the information ought to come in another manner that will enable his/her understanding of same. But the phrase “where possible” suggests that this provision does not carry an absolute imperative; there is still room for exceptions to the rule.

In the same vein, the Code of Medical Ethics in Nigeria<sup>66</sup> requires that ‘Care should be taken to ensure that all consent forms are also signed by witnesses. Discussion and explanation to the patient must be in the language in which the patient is fluent in and when necessary, through a competent interpreter’.<sup>67</sup> While the tone of the Code is more definitive, it does not, just like the National Health Act, make specific prescription regarding the steps to be taken in preparing and signing any document relating to decision-making of an illiterate person. The two instruments are merely interested in the process of communicating the relevant information to the patient – which is only the first stage of decision-making. This perhaps still leaves the need for a statute specifically dealing with such writing and signing in relation to illiterates making decisions in a clinical circumstance, just as obtained with illiterates making land transactions.<sup>68</sup>

### **3. Lack of Capacity: Nigeria versus Other Jurisdictions**

To further assess the adequacy or otherwise of the Nigerian legal system in terms of addressing the issues of lack of decision-making capacity in clinical settings, some comparison is made between the local jurisdiction and two selected foreign jurisdictions in this respect. This inter-jurisdictional comparison is intended to highlight areas of similarities and differences, and by this way, possibly expose strengths and shortcomings of the system that obtains in Nigeria currently. Two foreign jurisdictions are chosen for this exercise to wit: the United Kingdom and the United States of America.

#### **3.1. United Kingdom (UK)**

The choice of United Kingdom is informed by its status as Nigeria’s ex-colonial master and the originator of the Common Law tradition, a key source of our legal system. In fact, Britain is the mother of Nigeria’s legal system just as it is the mother of her political system. Consequently, whatever obtains in the Nigerian legal system, in most cases, could be viewed as directly or indirectly having a link with what obtains in Britain.

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

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<sup>65</sup> NHA, Act No. 8, FRN Official Gazette, 2014, S.23 (2).

<sup>66</sup> CMEN, 2004.

<sup>67</sup> CMEN, 2004, Rule 19.

<sup>68</sup> See the Instruments Registration Law of the Western State and its application in *Echefu & Ors v Emenike & Anor*, (2018) LPELR-43682 (CA).

against invasion by others”.<sup>69</sup> This integrity may be compromised without the individual’s consent only in certain defined circumstances – as where, for example, physical intrusion is involved in the carrying out of lawful arrest.<sup>70</sup> Definitely, it is on this principle that the right to consent possessed by a patient in both the UK and Nigerian jurisdictions is predicated. Both the English and Nigerian laws also recognise that the right to consent (autonomy) should not be absolute. For example, the Mental Capacity Act<sup>71</sup> provides for informed consent in its Section 4 and once an individual fails to satisfy the provisions of the Section, his right to individual autonomy would be intruded upon in his/her interest. Again, Rule 19 of the Code of Medical Ethics in Nigeria<sup>72</sup> provides for informed consent and went further to make provisions on how consent can be gotten in any circumstance where the patient lacks the capacity to consent to a proposed medical procedure personally. As argued by Selinger, “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>73</sup> Hence, both jurisdictions have exceptions to the rule of autonomy, and aspects of these exceptions relate to when a patient lacks capacity.

The English legal system has 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 situation-specific. In other words, a person’s age or mental state for instance may not be considered as imposing incapacity in all cases. Each situation must be considered in its merit taking into account the specific medical case involved, the kind of decision required, and the possible consequence thereof.<sup>74</sup> In *Re T*,<sup>75</sup> the claimant was a Jehovah’s Witness who had been given a blood transfusion when unable to give or refuse consent. The Court of Appeal addressed the question of whether the life-threatening circumstances were relevant to whether the patient’s capacity was sufficient for the refusal to be respected. The Court held that they were, observing that what ‘matters is that the doctors should consider whether at that time he had capacity which was commensurate with the gravity of the decision. The more serious the decision, the greater the capacity required’.

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<sup>69</sup> G T Laurie, S H E Harmon & G Porter, *Mason & McCall Smith’s Law & Medical Ethics* (10<sup>th</sup> ed, Oxford University Press, 2016) pp. 67-68.

<sup>70</sup> G T Laurie, S H E Harmon & G Porter, *op. cit.*, p. 68.

<sup>71</sup> MCA, 2005, Cap. C.9, s. 4.

<sup>72</sup> CMEN, 2004.

<sup>73</sup> C P Selinger, *op. cit.*, p. 54.

<sup>74</sup> The Mental Capacity Act, 2005, Cap. C9, 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 adjudging one as lacking capacity, what counts is the material time of decision-making and not *time in absolute terms*.

<sup>75</sup> *Re T* [1992] 4 All E.R. 649.

Also, in *Re B*,<sup>76</sup> two psychiatrists had assessed the capacity of the claimant, a tetraplegic patient who had wished that the ventilator which had kept her alive be switched off. The High Court of England and Wales noted that ‘her mental competence is commensurate with the gravity of the decision she may wish to make’. Also, when a patient has, after taking due cognisance of all the contextual elements as required by 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 much 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>77</sup> – should be considered. Obviously, such definite legal prescriptions appear to be largely lacking in the Nigerian legal system as evident in the earlier discussions. Neither the requisite statutory provisions nor decided Court cases appear to exist locally in this respect. The provisions in the National Health Act and Code of Medical Ethics in Nigeria appear too general to effectively deal with these intricate specifics.

However, both the English law and the Nigerian law insist that a patient’s consent must be an “informed consent” for his autonomy to be said to have been preserved.<sup>78</sup> This is evident in Section 23 of the National Health Act<sup>79</sup> which provides for the user’s right to have knowledge of the proposed medical procedure in order to engender informed consent. Also, for consent to be valid, it must be shown that the patient has the capacity to consent and that the consent was given voluntarily having understood the nature of the treatment.<sup>80</sup> By emphasising that one’s consent must be “informed” the law treats the patient as a distinct soul among all humans. Circumstances specific to their cognitive space as an individual now become a key factor – educational background of the patient, his/her 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 medical issues involved are – may, for instance, be understood differently when given by someone who has a medical background and when given by their counterpart without such a background.<sup>81</sup> However, a look at the Nigerian legal

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<sup>76</sup> *Re B* [2002] 2 All E.R. 449.

<sup>77</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 considerations” and that “all factors, including religious beliefs or values expressed by the patient when competent be taken into consideration”.

<sup>78</sup> C P Selinger, *op cit.*, p. 54. Compare with relevant provisions of Nigeria’s National Health Act and Code of Medical Ethics in Nigeria.

<sup>79</sup> NHA, Act No. 8, FRN Official Gazette, 2014.

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

<sup>81</sup> 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

provisions as earlier discussed still suggests that the English law is still ahead in terms of being explicit and specific about these issues.

In the English system, “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>82</sup> This provision is pertinent because it proceeds from the principle that benefit of doubt should be given to a person before adjudging 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 which impacts on one’s reputation and 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 given fair hearing before being pronounced “guilty”. This principle also obtains in Nigeria based on the provisions of the Code of Medical Ethics in Nigeria as seen earlier even though, admittedly, the principle is not as explicitly articulated as in the English system. In addition, the fact that the only legislation on mental health care – the Lunacy Act of 1958 – is silent on issues of decision-making implies that the nation’s jurisdiction still suffers visible shortcomings where incapacity is related to mental infirmity.

Furthermore, the English law allows individuals with capacity to make advance decisions to cover for any period where she or he becomes incapable to make decisions on her/his behalf. The only provision to this effect in the Nigerian law is found in the Code of Medical Ethics in Nigeria.<sup>83</sup>

As can be seen, the above provision is limited only to those who may object to treatment on grounds of religion. This is also clear from the heading of the section in question – ‘Clinical Management of Religious Adherents’. This provision is never mentioned in any other part of the Code as a matter of general application.

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

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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>82</sup> UK Medical Protection Society, 2014.

<sup>83</sup> Rule 39 (D), Code of Medical Practice in Nigeria, 2004.

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 to the community. On these two, the English law recognises the primacy of public interests over and above individual's interests. Though this principle may be upheld in Nigeria by relying on Section 45 of the Constitution of the Federal Republic of Nigeria (as amended) regarding restriction of rights of individuals in the public interest, the *lacuna* lies clearly in the fact that the Mental Health Bill which, as seen earlier, made explicit provisions in this regard, is yet to become a law in the country.

With regard to children, the Children Act<sup>84</sup> is the regulating law in England as was aptly demonstrated in the case of *B Local Authority v RM*.<sup>85</sup> The English law refuses to completely 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 writer's opinion, 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>86</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. Here, Mrs Gillick sought to challenge the legality of the Department of Health Circular which permitted doctors to provide contraceptive advice and treatment to under 16-year-olds without parental permission. The House of Lords held that it was lawful for a doctor to do so provided the child is sufficiently mature to understand the medical, social and family issues involved, and the child can provide an effective consent. Therefore, maturity and the ability to understand the issues determine whether a person was competent, rather than age. The majority emphasized that even if a child's parents do not want the child to have contraceptive advice, it was still open to a doctor to provide the advice if the child is competent to make the decision. Their Lordships dealt with two issues. First, it was emphasized that a doctor owes a child patient a duty of confidentiality and thus should not inform the child's parents of the visit. Second, their Lordships responded to an argument that the provision of contraception to an underage person could be regarded as a criminal offence of assisting in the commission of a child sex offence. The House of Lords held that the doctor could not be

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<sup>84</sup> 1989, Cap. C41.

<sup>85</sup> [2010] EWHC 3802.

<sup>86</sup> [1986] AC 112; [1985] 3 All ER 402.

guilty of an offence because she or he did not intend the child to engage in sexual intercourse.

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. As seen earlier, the Code of Medical Ethics in Nigeria has attempted to domesticate this rule by providing that 'Children younger than 16 but not below 13, though considered as minors, but of clear mind and can grasp the benefits and consequences of accepting or rejecting a proposed treatment, "Gillick-competence", can give an acceptable consent'.<sup>87</sup> However, since this is yet to receive the imprimatur of the legislature, it remains at the level of a subsidiary legislation and which applicability, as earlier suggested, may be adversely affected by the varying definitions of a child with his rights and privileges across the various States of the country.

Nevertheless, given the peculiarity 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>88</sup>

Similar provisions exist in Nigeria's Child's Rights Act<sup>89</sup> and Code of Medical Ethics in Nigeria.<sup>90</sup> However, unlike in the British jurisdiction, judicial pronouncements have backed and given better precision to these rules. In *Re W (a minor) (medical treatment)*,<sup>91</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. Court decisions overruling joint child-parent refusal to consent to life saving blood transfusion as a result of the family religious faith are well informed,

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<sup>87</sup> Rule 39 (B), Code of Medical Ethics in Nigeria, 2004.

<sup>88</sup> UK Ministry of Ethics 'Consent and Confidentiality' <<http://ministryofethics.co.uk/?p=6>> accessed 24 December 2020.

<sup>89</sup> CRA, Cap. C50, LFN 2004, S. 64 (1), S. 5 (a).

<sup>90</sup> See S. 39 (B), Code of Medical Ethics in Nigeria, 2004.

<sup>91</sup> [1992] 4 All ER 627.

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. Such presumption may be akin to holding the child hostage in the religious den of his parents.

The Code of Medical Ethics in Nigeria is very declarative on this principle:

A child who needs blood transfusion or procedures in any emergency should be so given. A practitioner who stands by and allows his minor patient to die in circumstances which might be avoidable may be charged with negligence and is also vulnerable to criminal prosecution.<sup>92</sup>

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 appears to be what the Nigerian system is trying to establish, albeit yet to develop adequate statutory provisions and case laws as may be required.

### **3.2. United States of America (USA)**

The choice of the United States of America (USA) as a comparative jurisdiction in examining capacity for decision-making in Nigeria stems from two reasons. First is that the USA has been acclaimed as an ideal model of the modern liberal democratic tradition. The nation's experiences and institutions are often cited as a notable example in the quest of nations to achieve progress in the context of liberal democracy. Secondly, though Nigeria was a former British colony and had inherited a lot from that country, her institutional set-up including legal system is not without some American imprint. The country's federal and presidential Constitutions are modelled on the American tradition, and like many nations she views America as a democratic model, relying on her for technical assistance in the democratisation project through agencies like the United States Agency for International Development (USAID) among others.

In the USA, the right to bodily autonomy is founded on the Constitution which grants individuals the right to privacy.<sup>93</sup> In *Schloendorff v Society of New York Hospital*,<sup>94</sup> Cardoso J expressed this right thus: 'Every human being of adult years and sound mind has a right to determine what should be done to his body....' In Nigeria, the Constitution also provides for the right to privacy.<sup>95</sup> However, unlike in the United States of America, this right appears not to have been articulated by the Court in relation to body autonomy.

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<sup>92</sup> CMEN, 2004, Rule 39 (b).

<sup>93</sup> See the Fourth Amendment to the USA Constitution.

<sup>94</sup> (1914) 105 N E 92.

<sup>95</sup> CFRN, 1999, as amended, S.37.

In the United States of America, like elsewhere, the question of determining who lacks capacity has been a problematic one. However, in most States, laws allow any physician to determine if a patient has capacity.<sup>96</sup> Generally, the attitude of the law about decision-making tends towards the same direction in both the Nigerian and USA jurisdictions. Spike summarises what obtains in the USA thus:

All adults are presumed to have decision-making capacity, though some may be determined to lack capacity after assessment. Before age 18, then, people (minors) are presumed to lack capacity. But that is only a presumption, and despite that presumption, some minors (especially older teens) may be determined to have capacity just as some adults may be found to lack capacity.... Every state has some legal carve-outs for minors, usually concerning such things as birth control and treatment for STDs.... Of course, some states do recognize mature minors and their right to make their own medical decisions. Those statutes recognize that some people can make mature decisions by age 14, and many can by age 16. The American Academy of Paediatrics has said most teens can probably make decisions about life-sustaining treatment by age 16. One can consider state carve-outs in most States, bolstered by mature minor statutes in a few states, as 'of a piece,' that is, related doctrines giving minors some rights over their own bodies.<sup>97</sup>

As seen from the foregoing, the USA jurisdiction retains some similarities with that of Nigeria in that every adult is presumed capable, but for a minor, capacity may be admitted at age of 16 or even below depending on the special circumstance. However, unlike in Nigeria, the USA law is more developed by way of being more specific on circumstances that will influence such presumption – such as whether the decision involves STDs, pregnancy, abortion or a life-threatening condition.<sup>98</sup> The following observation by Boonstra and Nash points to this fact:

The notion that many minors have the capacity and, indeed, the right to make important decisions about health care has been well established in Federal and State policy. Many States specifically authorize minors to consent to contraceptive services, testing and treatment for HIV and other sexually transmitted diseases, prenatal care and delivery services, treatment for alcohol and drug abuse, and outpatient mental health care. With the exception of abortion, lawmakers have generally resisted attempts to impose a parental

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<sup>96</sup> J P Spike, 'Informed Consent Is the Essence of Capacity Assessment' [2017 (45) *The Journal of Law, Medicine & Ethics*; p. 97.

<sup>97</sup> J P Spike, *op cit.* p.97.

<sup>98</sup> *Ibid.*, p. 100.

consent or notification requirement on minors' access to reproductive health care and other sensitive services. Nevertheless, the movement to "restore" parental rights and to legislate parental control over minors' reproductive health care decisions remains active.<sup>99</sup>

Also, one potential area of similarity is in the possible differences in the way decision-making law unfolds in various parts of the country. This is given that both the USA and Nigeria practise federalism resulting in sub-jurisdictions (along State lines) within the national jurisdiction. Admittedly, such differentiations are more emphatic in America given that her own federal structure admits of greater autonomy for States than that of Nigeria. Interestingly however, the USA Supreme Court had affirmed the right of a 17-year-old minor to reject blood transfusion at the risk of death even though the State of Illinois law has 18 years as the age at which such decision can be made.<sup>100</sup>

Again in the USA, like in Nigeria, parents can make decisions for their children. However, specifics may differ from State to State. On this, Boonstra and Nash observe that:

States have traditionally recognized the right of parents to make health care decisions on their children's behalf, on the presumption that before reaching the age of majority (18 in all but four States), young people lack the experience and judgment to make fully informed decisions. There have long been exceptions to this rule, however, such as medical emergencies when there is no time to obtain parental consent and in cases where a minor is 'emancipated' by marriage or other circumstances and thus legally able to make decisions on his or her own behalf.<sup>101</sup>

Similarly, the two jurisdictions have room for intervention by Courts to overrule a minor's or a parent's decision.<sup>102</sup> In *Re Ernestine Gregory*,<sup>103</sup> the trial Court had earlier overruled the minor's decision and ordered blood transfusion in spite of the evidence that the patient had sufficient maturity to make such decision. However, the USA Supreme

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<sup>99</sup> H D Boonstra & E Nash, 'Minors and the Right to Consent to Health Care' <https://www.guttmacher.org/gpr/2000/08/minors-and-right-consent-health-care> Accessed 25 February 2019.

<sup>100</sup> *Ernestine Gregory* 133 IU 2d 98549 NE 2d 322 [1989].

<sup>101</sup> Boonstra and Nash, *op cit.*, p. 2.

<sup>102</sup> P F Clark, 'When Patients Lack Capacity' <<https://www.medicalprotection.org/southafrica/advice-booklets/common-problems-managing-the-risks-in-hospital-practice-in-south-africa/when-patients-lack-capacity>> Accessed March 1 2019.

<sup>103</sup> *Re Ernestine Gregory* 133 IU 2d 98549 NE 2d 322 [1989].

Court affirmed the no-blood transfusion decision of Ernestine, a 17-year-old Jehovah Witness being treated for Leukaemia.

In the case of *Georgetown College v Jones*,<sup>104</sup> a University hospital requested for an urgent Court order to allow blood transfusion of a Jehovah Witness patient and the Court refused based on the patient's right to refuse unwanted medical treatment. The college attorney appealed against the ruling instead of respecting the patient's right to refuse. The judge visited the *locus* to see the patient for himself consequent upon which he ordered for the transfusion to be done in the belief that the patient has lost up to 60% of blood and is lacking in decisional capacity. He further added that since the lady has a seven month-old child, her decision to die constituted an abandonment of the baby which the State has the power to stop. He further reasoned that accepting her refusal to accept medical treatment will place both the hospital and the doctors at the risk of legal liability. Although the earlier decision of the Court in *Re Ernestine Gregory*<sup>105</sup> was overruled, what is clear from the above two cited cases, is that Courts would intervene depending on the circumstances of a given case to override a patient's right to make decision in the interest of justice irrespective of the patient's capacity to make such a decision.

On the whole, it would appear that while the USA and Nigerian jurisdictions tend towards a common libertarian principle that seeks to respect individual's autonomy while balancing this with other interests, it is in the very dynamics of achieving this balance that the difficulties associated with patients' right to autonomy and decision-making lie. However, the USA jurisdiction is obviously more developed than her Nigerian counterpart in terms of dealing with the specifics of the process. These specifics are a function of statutory provisions and case laws.

#### 4. Conclusion

From the discussions above, it is clear that Nigeria still has some important grounds to cover in terms of evolving an efficient legal framework for addressing the question of lack of capacity to make decisions in clinical setting. Compared with UK and USA, Nigeria is still lagging behind in terms of statutory and case laws in this aspect of her legal system. That Nigeria is still significantly far behind the UK from whom she had largely copied her legal system calls for concern as it tends to suggest that the country has failed to progress on this front. For instance, the fact that the Lunacy Act inherited from UK in 1958 is still the major statute regulating standards in mental health care in Nigeria whereas the UK has made significant adjustment in this aspect of her law since then, makes an important statement in this regard. Thus, it is strongly contended that the Mental Health Bill which was re-introduced in the National Assembly in 2013 be passed into law to help Nigeria make a head-way towards filling the *lacuna* regarding informed

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<sup>104</sup> [1964] 331 F.2d 1 1000.

<sup>105</sup> *Supra*.

consent and decision-making in medical practice in Nigeria. Hence the need to pass into law the Mental Health Bill in line with the articulated terms of the National Policy Document for Mental Health Services Delivery in Nigeria.