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Informed Consent and Individual Autonomy: Beyond Paternalistic and Individualistic Considerations

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Abstract

Informed consent requirements are ubiquitous in healthcare and are regarded as cornerstone of ethical medical practice. Informed consent is more than just obtaining a patient's signature on a document, it is a continuous process involving answering patient's questions and providing information as his treatment goes on or as the situation demands. It is a truism that these requirements are justified by the principle of respect for individual autonomy. It is the right of the patient to determine his/her own health issues. A patient has the right to be involved in the decision- making process regarding his health care and health professionals should always try to ensure that people are not treated against their will. It requires that the agent/patient has the capacity for decision-making, that he be informed and his decision be voluntary. The relationship between health care professionals and patients is one that has divided opinions. Some scholars, who advance paternalistic arguments, argue that peoples' interest such as life, health and safety are more important than their liberty, and so because medical professionals have more expertise than the patient, they are best placed to take decisions beneficial to the patient. On the other hand, others, the individualists argue that the patient has absolute rights over his/her health and body and thus must be actively and fully involved in any decision regarding his health. This paper draws a middle ground between both extremes and argues for a team work to treatment. It recommends that the medical professional, the patient and his family should decide together what is to be done in the case of a patient.

Keywords: Informed consent; individual autonomy, biomedics, ethics, moral responsibility, paternalism.

Introduction

In September 2024, my 11 year old son underwent a surgical operation to repair a hole in the stomach. As the boy was being prepared to be taken to the theatre for the commencement of the operation, a document was brought to me to sign. With the document on my hand, I asked for a few minutes to read and understand the provisions of the 'agreement' but was told the procedure was urgent. I asked that the dangers and risks inherent in the procedure be explained to me in clear terms. The theatre attendant asked if I was questioning the competence of the doctor who he described with such glowing terms like 'expert', 'guru', 'the best around' and so on. With very little choice left, I signed the document but that left me worried. What if I have signed my son's life away? Should anything go wrong, what moral and legal right will I have to hold the doctor and hospital responsible? Why were the dangers and risks clouded in secrecy?

The procedure was carried out anyway and my son came out and has since then healed. As I thought about the incident, the question of whether the consent I gave by signing the document was informed or not, why are issues such as this not given adequate attention in Nigeria's healthcare practice? Why do patients and their families not demand full disclosure and why do medical and health professionals feel consent is just about signing a document and that they do not have the obligation to disclose the inherent dangers and risks? This complacency on the part of health professionals and patients is a huge issue in the relationship between the professionals and the patients. According to Gerald Dworkin, the doctrine of informed consent is a creation of law, in other words, it is part of the law of many countries that one party obtains the consent or approval to perform some course of action on another to which the consented party would otherwise have no moral right to perform. This supposes that A morally ought to obtain B's informed consent to perform some course of action (x) on B. This moral responsibility is grounded on the following requirements being met:

1. B must be sufficiently informed with regards to the relevant facts concerning the course of action (x) intended by A and B understands what x involves and the likely consequences resulting from x.
2. On the basis of the information provided by A, B makes the decision to allow A to perform x.

The above scenario painted by Dworkin presents us with an idea of what informed consent involves. It is understood as shorthand for a patient's informed, voluntary and competent consent to or refusal of treatment, which amounts to a valid authorization or refusal of a medical procedure or intervention. It stands in sharp contrast to the original Hippocratic Oath which holds that "I swear by Apollo and Aesculepius that I will follow that system of regimen which according

to my judgment I consider best for the benefit of my patients…. **Conceal most things from the patient**……give necessary orders with cheerfulness and serenity….revealing nothing of the patient's future or present condition."

Patients' autonomy and right over their bodies have received increased attention in medical ethics since the 1960's. Respect for autonomy is often felt to be the most important principle of bioethics and emphasis on it has increased as a result of the works of scholars such as Ruth Faden, Tom Beauchamp and James Childress. Informed consent arose as a response to the paternalistic model in which the physicians were rarely questioned because they were often presumed to be competent and knowledgeable. It was developed as a means to operationalize respect for autonomy.

The relationship between individual autonomy and informed consent has necessitated the question of what the ideal relationship between the physician and the patient should be. What amount of freedom a physician should exercise over decisions involving a patient's health and whether a patient has the final say or a say at all have divided opinions among bioethicists and medical practitioners. While we have come a long way from the paternalistic model of professional-patient relationship engendered by the original Hippocratic Oath, many physicians as I discovered with my son's procedure still hold on to their presumed competence and knowledge to deny patients and their families such information as are needed to make informed consent. The individualists who depart radically from the above model place the power of decision-making (at least most of it) in the hands of the patient. Because they see the patient as an autonomous individual, they hold that he has absolute control over his healthcare choices while the role of the doctor begins and stops at primarily providing information and executing the patient's treatment plan, regardless of his own expert opinion.

This paper considers both models and finds them inadequate in their lack of respect for the autonomy of the patient whose life is at stake and lack of recognition and respect for the physician's expertise and knowledge. It therefore recommends what is referred to here as the collegial model which encourages open communication and collaboration between the physician, the patient and his family to reach a treatment plan mutually agreed upon. This model allows the physician to deploy his wealth of experience, expertise, competence and knowledge while acknowledging and respecting the autonomy and dignity of the patient.

Informed consent

Berg et. al. (1995) describe it as a legal construct focused on the disclosure of information to the patient and the promotion of autonomy. It gives the patient

an opportunity to agree or reject a medical procedure or a particular treatment regime and affords the health professional the occasion to assess the patient's capacity for decision-making. Iroegbu (2005), defines it as a process in which a patient gives written consent (agreement) to undergo a medical procedure after having being provided with information about the nature of the procedure, risks, potential benefits, alternatives, and so on by his or her doctor (658). Ekwutosi (2008), says it is one of the two ethical principles deriving from respect for persons, the other being truth telling. He goes on to define it as a legal condition whereby a person can be said to have given consent based upon an appreciation and understanding of the facts and implications of an action. He identifies several factors that would permit a valid consent: possession of relevant facts and his reasoning faculties by the individual. In other words, the individual must not be mentally retarded or ill; there must not be an impairment of judgment such as illness, intoxication, insufficient sleep and other health problems at the time of consenting.

White (2013) believes as with most philosophers that the requirement to employ informed consent is grounded in autonomy and its core notion is the idea of steering the direction of one's life, determining how to behave and deciding what projects to engage in. In other words, if steering one's life is the essence of autonomy, White holds that autonomy is best protected and facilitated through the employment of informed consent procedures. What holds here she says is that a patient must endorse a proposed course of action in line with his intentions and affirms that the decision is his. What is required here is not just consent but informed consent which places emphasis on providing information to a patient, and making sure that it is adequately understood. The provision of relevant information is particularly important to autonomy, since this information may enable him to better steer his life in the direction he chooses. Thus, informed consent guidelines provide an appropriate means of protecting and facilitating autonomy in patients.

From the above, we glean that informed consent involves a formalized procedure, whereby patients and their families consent, usually in writing for certain medical procedure or treatment to be carried on and given that has some undesirable side effect. The idea behind it is that the physician has a duty to informed patients of the benefits and risks of a procedure and including the consequences of no treatment and to obtain a consent voluntarily given by the patient. While it gives the patient the opportunity to accept or reject a given medical modality, it also provides the practitioner the occasion to assess the patient's capacity for decision-making. That informed Kutner et al (1991) claim that for consent to be valid:

> conditions of disclosure of information, competency, understanding, freedom from coercion and presence of decision - making must be met. In theory, true informed consent occurs when a physician provides information to a competent patient who understands the data and voluntarily makes a decision to accept or refuse the recommendation.

From Kutner et al above, three essential elements of informed consent stand out: the agent must have *capacity* for decision-making (understanding), the agent must be *informed* (through disclosure of potential risks and benefits of the treatment modality) and the agent's decision must be *voluntary*.

Autonomy

This is one the principles enunciated by Beauchamp and Childress upon which modern day bioethics stands, the others being Beneficence (the moral requirement to contribute to others' welfare), Non-Maleficence (the obligation to abstain from causing harm to others) and Justice (equality in access to healthcare and in health status). (Beauchamp and Childress, 2001). These four principles have withstood challenges for nearly three decades and still form the basis for most decision-making in both clinical practice and biomedical research (Harish et al, 2015). Autonomy is derived from the Greek word *autonomos* which implies self-rule, self-governing, self-determination and independent. It requires the ability to decide for oneself, sufficiently free from control and control of others or conditions, to live by one's own standards and having capacity to decide upon a course of action, and to put that plan into action.

Philosophers have argued that there is no consensus regarding how personal autonomy should be understood. In fact, as Taylor (2009) opined, the many faces of autonomy may not be as numerable as some have suggested. Autonomy in the moral sense is a property belonging to human persons which they can enjoy to different degrees. This suggests that non persons such as very small children, animals and inanimate objects cannot be autonomous in that sense. Because autonomy can be enjoyed in different degrees, it is not a binary concept. In other words, a person can be more or less autonomous as well as non-autonomous and fully autonomous and it has both positive and negative elements. Speaking in a positive, autonomous persons are capable of qualitative self-reflection, can assess their own desires and values and can chose whether they are to be influenced or controlled by the values and choices. In a negative sense, autonomous persons are not subject to the control of others and to a large extent are in charge of those influences from outside.

Gillon (2003) defines it as deliberated self-rule; the ability and tendency to think for oneself; to make decision for that thinking, and then to enact those decisions.

He says it is what makes any sort of morality possible. Motloba (2018), traced the evolution of autonomy to ancient Greece, a period in which cities while defended their sovereignty and freedom from the influence of foreign powers and wrote that in modern days, the idea of autonomy addresses personal or individual autonomy insofar as the agent may elect to act, or not to act according to specified prescribed standards, norms or rules (which may have neutral value or be value laden). This supposes that autonomy denotes the condition when an agent may determine the conception, articulation and the execution of concepts, ideas and actions for him or herself. Its commonest usage implies actions or thoughts that are characterized by the presence of freedom, rationality and consistency with one's own preferences (Agich, 2009). Smith (1994) expanded the definition of autonomy to include a 'set of diverse notions including self-governance, liberty rights, privacy, individual choice, liberty to follow one's will, causing one's own behavior and being one's own person.

Relationship between healthcare professionals and patients

Here, we focus on the relationship between the physician and the patient which is an important foundation of the medical ethics. In the past, this relationship was a concern only to healthcare professionals. Given that they are presumed to have greater knowledge and have the patient's best interest at heart, they were entrusted with making life changing and critical decisions for the patient. Today, however, with advancement in medical technological, the range of people who have an interest in the decisions and who in some cases have a right to, have grown. Two views; paternalism and individualism have dominated discourse about this relationship. Here we discussed them, examined their strengths and weaknesses but ultimately found them inadequate. A new view on the strength of the examination is proposed.

Paternalism (paternalistic model)

Paternalism comes from the Latin word *pater* which means father. This refers to the way a father/parent would normally treat his own child. It is to act in the best interest of another without necessarily the consent of the person as parents do with their children. It involves the intentional limitation of the autonomy of one person on the ground of beneficence by who has some amount of authority over him, it is controversial because while its end is benevolent, its means is coercive. Paternalists appeal to peoples' interests such as life, health and safety over their liberty and right to freedom of choice. They ground their act on the relatively greater knowledge they are presumed to have or sometimes the ignorance of him whose liberty is being restricted. Generally, It is the interference of a state or an individual with another person, against the person's will, and justified by a claim that the person interfered with shall be better off or protected by harm. The government's paternalistic

decisions can be seen in areas like anti-drug legislation, compulsory wearing of seat belts and so on.

In medical ethics and healthcare, paternalism refers to healthcare professionals making decisions for patients without their consent and inputs, based on the belief that they know better than the patients what they need and this potentially limits the patients' autonomy. Paternalism constitutes of any action, decision, rule or policy made by a physician or other care-giver or a government that dictates what is best for the patient without considering the patient's own beliefs and value system and does not respect patient's autonomy (Ekwutosi, 2008). Due to the great medical expertise which physicians are presumed to have and which patient does not possess, they have an obligation to act beneficently towards the patient in recommending treatment procedure that they truly believe benefits the patient. A healthcare provider acts in a way that prioritizes his presumed knowledge and expertise over the patient's autonomy and rights to make decisions. In medical context, A physician withholds relevant information concerning a patient's condition from him. It is assumed that the patient will be thankful to the physician for decisions made even if he would not agree with it at the time (Stone, 1976). The physician is more interested in promoting a patient's well-being and health rather than his autonomy and choice. He acts as the patient's guardian articulating and implementing what he thinks is best for the patient. Thus he places the patient's interests above his and can solicit the views of other physicians when he lacks adequate knowledge of the issue.

As already stated, the dilemma here lies in the strong need to balance the principle of beneficence which involves acting to contribute to the patient's welfare with the principle of respect for the autonomy of the patient. Those who promote paternalistic view argue that because patients lack the capacity to make informed decisions about their health and because the medical professionals know the best with regard to the condition of the patient owing to their long years of training in medical schools and the great experience they have gained from practice, decision about what to do should be left to the medical professionals. They also argue that a physician may intervene paternalistically when a patient is unwilling or refuse to accept medical advice or treatment options proposed by the physician or when he requests treatments that are medically unsound or has the potentially to harm his health. Opponents, however, argue that paternalism among other things denies patients the right to make their own decisions about their bodies and treatment procedure even if those decisions differ from what the physician proposes/offers. This they argue, can lead to distrust between the patient and the physician and so affect the patient's recovery.

Individualism (Individualistic model)

In this model of physician-patient relationship, the patient is seen as having absolute right, autonomy and control over his body and health. Here the doctor is obligated to carry out the request of the patient even if he does not agree with it. In contrast to the paternalistic model, this model rests on the autonomy of the individual and the right of the patient to make decisions about his medical care without the physician or healthcare provider trying to influence the decision. While patient's autonomy allows the physician to educate the patient about the medical procedure or treatment, it does not allow him to make the decision for the patient. Autonomy here refers to the capability and right of a patient to control the course of his own medical treatment and participate in decisions concerning his treatment. Physicians are obligated to provide information and services, rather than make decisions for the patient. Their primary role is to inform the patient about all he needs to know about diagnoses, treatment options and possible outcomes/consequences and then to do as the patient wishes or chooses irrespective of personal opinions. Ekwutosi (2008) admits a legal limit of patient's autonomy usually framed under the rubric of informed consent. Every human adult of sound mind has a right to determine what shall be done with his body and any surgeon who performs a surgical operation on a patient without his consent commits assault liable to damages. The ethical question raised by this model concerns the conflict between a patient's autonomy and the physician's professional judgment.

Informed consent in Nigeria's medical practice

In medical ethics, the doctor-patient relationship is a central concern as it focuses on how best the interaction between the two can be nurtured (Smith, 1996). It is that interface between the two where patient's data are gathered, diagnosed and plans for treatment made, compliance accomplished and support and healing provided (Lazare, 1996). It is according to Dwolatzky et al (2006), a consensual relationship in which the patient knowingly seeks the help of a physician and the physician knowingly accepts to render the service the patient seeks. This relationship is not just an interaction between the doctor and patient but also involves significant others such as patient's relatives and neighbours, nurses, technical support personnel, hospital administrators, health insurance companies, government and so on. It is the foundation of clinical care and can have profound implications on clinical care. Its main goal is to improve patient health outcomes and their medical care. Tawari and Boloya (2021) assert that improved patient outcome is a function of physician-patient relationships.

According to the Code of Medical Ethics in Nigeria (Part A, section 19), informed consent is the permission granted in full knowledge of the possible consequences, typically that which is given by a patient to a doctor for treatment

with knowledge of the possible risks and benefits. Apart from the major elements of informed consent already outlined, it is important that the patient has sufficient time to weigh his options before making a decision. The concept of informed consent is not an alien practice in Nigeria. The regulation of informed consent in Nigeria does not seem to be altered by any unique attribute of the local culture or social context. This as Ojo (2021) is a consequence of the country's colonial heritage and the multicultural nature of Nigerian society. The stipulations and the notion of autonomy and human rights espoused in the Code of Medical Ethics in Nigeria resemble that of any developed western country. It recognizes that consent can be obtained from the patient, his/her relations, or the public authority, depending on the situation. While the first right to give a nod to any treatment resides with the patient, a next of kin can give consent for minors and those without capacity. However, when no relative is available, the most senior doctor in the institution can give an appropriate directive to preserve life. A court order may also be needed in special circumstances.

The Code specifies that a proper informed consent must include (1) the benefits and risks of a procedure, (2) appropriate professional advice on options, (3) the patient's choice of preferred option and (4) authorization for the clinician to commence treatment by completing the form. The Code recognizes the inherent right of a patient to his/her body and life. It is important to note that because the Nigerian legal system is built on British laws, most procedural cases are derived from that legal system. Medical practice in Nigeria is relatively free of malpractice litigations compared to developed countries (Ojo, 2021). Accusations of medical negligence, incompetence and unethical or unprofessional conducts are common, but are most times handled in house by the Medical and Dental Council of Nigeria. Its decision though can be appealed in any regular court in Nigeria but such is an exception in Nigeria (Ezeome and Marshall, 2008).

Within the Nigerian context, local, social and cultural factors have an effect on how the elements of a valid informed consent (voluntarism and capacity, disclosure and understanding, consenting or refusing) are applied in the patient-physician relationship. Arinze-Umobi and Okeke (2020) enumerated these key socio-cultural factors: low educational background; role of religion; effect of healthcare financing; influence of family structure; inadequacy of consent laws in Nigeria, poverty and respect for elders. The physician is such an authority figure in medical matters that patients feel obligated to follow whatever he tells them (Ojo, 2021). Medical paternalism is the norm in Nigeria and patients expect that their doctors direct them; in fact, some patients actually view the doctor's request for their views and choices as a sign of incompetence on his part. Paternalism is, however, not a unique cultural phenomenon and has occurred at one time or another in the history of all modern societies. It is a hallmark of traditional societies with high levels of illiteracy and

ignorance. Consequently, Nigerian physicians believe that their patients do not like inconsiderate 'cold shower' approaches to risk disclosure (Marshall, 2001). She believed that many of the disclosures carried out in Western settings would be viewed negatively by Nigerian patients.

It is, therefore, necessary that doctors striving to practice informed consent in Nigeria to spend time educate the patients and consciously and tactfully bring them into the decision making process of the relationship. The healthcare delivery in Nigeria has recorded unimaginable and unsatisfactory performance in quality delivery for a very long time. Quality medical services are still not within easy reach of many people. When accessed, patients most times receive very poor service due mainly to the negligence of healthcare providers. In cases where services are unaffordable, patients resort to quacks for cheaper costs and in the process cause greater damage or harm to the already precarious situation. Adebayo (2020), while investigating the role of power in physician-patient interactions in Nigeria revealed that physicians in Nigeria have low communication efficacy which is mostly characterized by their lack of interpersonal relations, empathy and depth of information disclosure. Many patients visiting Nigerian hospitals as was my case in September 2024 have reported.

Can a Middle Ground be Found Between Paternalism and Individualism?

Given the inadequacies of both paternalism and individualism in addressing individual autonomy and doctor's competence and expertize, there is need to find a middle ground to reconcile both extremes. The answer lies with what Ekwutosi (2008) calls the "Collegial View." This model of doctor/patient relationship emphasizes a team work to treatment. The doctors, patients and their families are seen as equal and should therefore collaborate and decide together what is to be done and choose the best course of action for a patient.

In the collegial view, the doctor recognizes the rights of the patient and their families in the treatment of the patient. The patient /families in turn acknowledge the expertize of the doctor and other healthcare professionals. In other words, it promotes the spirit of dialogue and co-operation. Collegial view aims to find a balance between the two extremes of paternalism and individualism, between the doctor's own values and patient's autonomy. Doctors' expertize it has to be said does not confer on them the ultimate right to make decisions for the patients. Competent patients can exercise the right to make decisions that advance their health and welfare by providing or withholding informed consent to the proposed treatment procedures by their doctors. All the information the patients need to make decisions should be provided as much as possible, but the information should not be forced on him.

Collegial view is characterized among other values by (1) equality and mutuality: doctors and patients are seen as equals with the patient's values and preferences and the doctor's expertize respected and acknowledged, (1) shared decision-making: the doctor and patient collaborate to choose the best course of action with the active involvement of the patient, (3) trust and respect: both parties feel heard and valued. This promotes mutual trust and respect. (4) open communication: collegial model encourages open communication, leading to the understanding of the issues involved and the options available.

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