ENHANCING PATIENT AUTONOMY THROUGH THE REFORM OF INFORMED CONSENT IN NIGERIAN HEALTHCARE

By

Mohammed Amali*
&
Doris Dakda Aaron**

Abstract

Informed consent is a fundamental principle of medical law and a critical mechanism for safeguarding patient autonomy. However, in Nigeria, its operation often remains more formal than substantive, with persistent gaps in disclosure standards, patient comprehension, and enforcement undermining meaningful autonomous decision-making. This paper examines the adequacy of Nigeria's legal and regulatory framework governing informed consent and argues that existing protections fall short of contemporary patient-centred standards. Adopting a conceptual and normative approach grounded in autonomy theory and a rights-based framework, the article interrogates informed consent both as a legal doctrine, and as an expression of constitutional values, particularly the rights to dignity and privacy under the Constitution of the Federal Republic of Nigeria, 1999. It analyses the doctrinal foundations of informed consent, assesses the strengths and limitations of Nigeria's existing regime, including the National Health Act 2014 and professional ethical regulations, and identifies structural and normative impediments to effective consent practices. Drawing on comparative lessons from two jurisdictions- the United Kingdom, and the United States of America, the paper demonstrates the importance of patient-centred disclosure standards, statutory clarity, and stronger accountability mechanisms in strengthening informed consent. It argues that reform should move beyond formal recognition of consent toward a framework that prioritises material risk disclosure, patient understanding, standardised consent procedures, and enforceable safeguards. The paper recommends that enhancing patient autonomy in Nigerian healthcare requires a reorientation of informed consent from a procedural requirement to a substantive legal right supported by coherent reform and effective implementation

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* LLB (*Univ. of Maiduguri*), BL, LLM (*Huddersfield, UK*), PHD (*Huddersfield, UK*), *f. CIFIAN*, Senior Research Fellow, National Institute for Legislative and Democratic Studies, (National Assembly), *amalimoh@yahoo.com; +2348036091751; Orcid: https://orcid.org/0000-0001-5967-6273*

** LLB (Univ. of *Jos),* BL, LLM (*Univ. of Lagos),* PHD (*Univ. of Abuja*) Senior Research Fellow, National Institute for Legislative and Democratic Studies, (National Assembly), *get2doris80@gmail.com; +2348034916563*

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1. Introduction

Informed consent is an essential requirement of lawful medical practice and a central mechanism of realising patient autonomy.[1] It aligns medical intervention with legal and ethical standards by ensuring that individuals retain control over decisions affecting their bodies.[2] In contemporary healthcare systems, consent is no longer viewed as a procedural formality, but a substantive safeguard against arbitrary or uninformed medical decision-making.[3] In Nigeria however, a significant gap persists between the formal recognition of informed consent and its practical implementation.[4] While statutory and ethical frameworks acknowledge the necessity of consent, contemporary realities often reflect limited disclosure, inadequate patient understanding, and residual paternalistic attitudes within the medical profession.[5] Consequently, patients frequently consent to procedures without full appreciation of risks, alternatives, or consequences, raising serious concerns about the validity of such consent. Or in some cases, patients are subjected to the consent of other individuals over their health care needs.

Against this backdrop, and adopting a doctrinal and analytical methodology, the paper examines Nigeria's existing legal and regulatory frameworks about informed consent in medical healthcare. It argues that the Nigerian legal framework governing informed consent remains underdeveloped and insufficiently aligned with modern patient-centred standards. It contends that meaningful enhancement of patient autonomy requires targeted legislative reforms grounded in autonomy and rights-based

1 Bazzano LA, Durant J, Brantley PR, 'A Modern History of Informed Consent and the Role of Key Information', Ochsner J. 2021, Spring; 21(1): 81-85. doi: 10.31486/toj. 19.0105. PMID:33828429; PMCID: PMC7993430.

2 Chima, S.C., 'Evaluating the Quality of Informed Consent and Contemporary Clinical Practices by Medical Doctors in South Africa: An Empirical Study', BMC Med Ethics 14 (Suppl 1), S3 (2013), <https://doi/10.1186/1472-6939-14-S1-S3> accessed 24 April, 2026.

3 Emanuel EJ, Joffe S. Informed Consent. In: Kufe DW, Pollock RE, Weichselbaum RR, et al., editors. Holland-Frei Cancer Medicine. 6th edition. Hamilton (ON): BC Decker; 2003. Available from: <Informed Consent - Holland-Frei Cancer Medicine - NCBI Bookshelf> accessed 24 April, 2026.

4 Prof. M. N. Umenweke, Ifeoma B. Okoye, 'A Review of the Extant Law and Practice of Informed Consent in Medical Procedures in Nigeria', <Vol. 1 No. 1 (2024): Journal Of Law and Clinical Legal Education | Journal Of Law And Clinical Legal Education> accessed 24 April, 2026.

5 Ezeome ER, Marshall PA, 'Informed Consent Practices in Nigeria', Dev World Bioeth. 2009 Dec;9(3):138-48. doi: 10.1111/j.1471-8847.2008.00234.x. Epub 2008 Apr 29. PMID: 18452553.

principles, capable of transforming informed consent from a nominal requirement into an enforceable legal right.

The paper is divided into five parts. Part 1 provides the introduction. Part 2 undertakes a conceptual analysis of informed consent and outlines the theoretical framework of the paper. Part 3 presents a doctrinal analysis of the legal framework of informed consent in Nigeria, while Part 4 provides a comparative analysis of the United Kingdom and the United States of America. Part 5 presents the key findings, recommendations, and conclusion.

2. Conceptual Analysis and Theoretical Framework

2.1 Conceptualising Informed Consent

Informed consent in contemporary medical law, denotes more than just an acquisition of a patient's agreement to treatment. It encapsulates a structured process of communication through which a patient is provided with adequate, relevant, and intelligible information to enable an informed and voluntary decision regarding medical intervention.[6] This distinguishes informed consent from "bare" consent, which is legally deficient where material information is withheld or inadequately conveyed.

Informed consent is constituted by four essential elements of disclosure, comprehension, voluntariness, and capacity. Disclosure requires that the patient is informed of the nature and purpose of the proposed intervention, its attendant risks and benefits, and any reasonable alternatives.[7] Comprehension ensures that such information is understood, noting the patient's linguistic, educational, and socio-cultural context.[8] In this context, disclosure alone is insufficient because the patient must understand material risks, benefits, and alternatives.[9] Voluntariness demands that the decision is free from coercion, undue influence, or manipulation.[10] It requires that there is no pressure from doctors, family, or institutions undermining choice. The consent must reflect free will. Capacity concerns the patient's legal and cognitive ability to make decisions.[11] It refers to the capacity of the patient to understand information, appreciate consequences, and to make and communicate a decision.

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6 Anne-Maree Farrell, Edward S Dove, 'Mason and McCall Smith's Law and Medical Ethics, 12th edn., OUP, 2023. 412.

7 *Canterbury v Spence*, 464 F.2d 772 (D C Cir. 1972).

8 Tom L Beauchamp, James F Childress, 'Principles of Biomedical Ethics (8th edn, OUP 2019) 121-125

9 *Ibid*.

10 *Ibid*.

11 *Ibid*.

A further conceptual distinction arises between professional-centred and patient-centred standards of disclosure.[12] Under the former, the scope of disclosure is determined by medical practitioners in accordance with professional norms. This was the position enunciated in *Bolam v Friern Hospital Management Committee,*[13] where the court held that a doctor is not negligent if they act in accordance with practice that is accepted by a proper responsible body of medical professionals, even if other professionals disagree. By contrast, the patient-centred standard prioritises the informational needs of the patient, particularly with respect to risks that a reasonable patient would consider material. The global trajectory of medical law increasingly favours this latter approach, reflecting a shift toward participatory and rights-conscious healthcare. This was the decision of the UK Supreme Court in *Montgomery v Lanarkshire Health Board,*[14] where the court expressly affirmed that disclosure must focus on what a reasonable patient would want to know, marking a clear rejection of the professional-centered approach as enunciated in Bolam.[15]

Accordingly, informed consent is best understood not as a discrete event, but as a continuing process of engagement, requiring meaningful dialogue between healthcare provider and patient. Its validity depends not only on the provision of information, but on the quality of communication and the patient's ability to exercise genuine choice.

2.2 Theoretical Framework

2.2.1 Patient Autonomy

The primary theoretical foundation of informed consent is the principle of patient autonomy, which affirms the individual's right to self-determination in matters affecting their body and health.[16] Autonomy, in this sense, denotes the capacity and freedom of individuals to make decisions based on their own values, beliefs, and preferences, free from external control or coercion. Within medical contexts, it requires that patients are treated not as passive recipients of care, but as active participants in decision-making processes.[17] Informed consent therefore functions as the legal mechanism through which autonomy is operationalised. By ensuring that patients are adequately informed and free to choose, it transforms medical decision-making into a collaborative process.

12 Sidney W DeLong, 'The Standard of Disclosure in Medical Practice', (1982) California Law Review, 590.
13 (1957) 1 WLR, 582.
14 (2015) UKSC, 11.
15 *Ibid*, 13.
16 n.8.
17 *Ibid*.

This stands in contrast to the traditional model of medical paternalism, where physicians unilaterally determine what is in the patient's best interest.[18] While paternalism may be justified in limited circumstances, its continued dominance undermines the very essence of autonomy.

The shift toward patient-centred care therefore, reflects an increasing recognition that respect for autonomy enhances not only legal compliance but also trust, accountability, and the overall quality of healthcare delivery. In this regard, informed consent serves as both a procedural safeguard and a substantive expression of individual liberty.

2.2.2 Rights-Based Approach to Informed Consent

Complementing the autonomy framework is a rights-based approach affirmed by the Universal Declaration of Bioethics and Human Rights which situates informed consent within the broader architecture of fundamental human rights.[19] Adopted by the United Nations Educational, Scientific and Cultural Organization (UNESCO),[20] the Declaration articulates ethical principles to guide scientific and medical practices in respect of human dignity, rights, and cultural diversity. It extends human rights discourse into bioethics, promoting equity, informed consent, and solidarity in the life sciences. Under this approach, the requirement of informed consent is not only an ethical obligation imposed on healthcare providers, but a legal entitlement vested in patients.

In the Nigerian context, this entitlement derives prescriptive support from constitutional guarantees under the Constitution of the Federal Republic of Nigeria 1999, particularly the rights to dignity of the human person[21] and privacy.[22] These rights underscore the principle that individuals have control over their bodies and personal information, and that any medical intervention without proper consent may constitute an infringement of these protected interests. Framing informed consent as a rights issue has important implications. It elevates the doctrine from the realm of professional discretion to that of legal accountability, thereby strengthening the case for enforceable standards and remedies. It also provides a constitutional basis for challenging inadequate consent practices and for advocating legislative reform.

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18 n.14.
19 Articles 5-6.
20 Adopted on the 19th of October, 2005.
21 Section 34; *Mojekwu* v *Mojekwu* (*1997*) *7 NWLR* (*Pt 512*) *283*.
22 Section 37; *Medical and Dental Practitioners Disciplinary Tribunal* v *Okonkwo* (*2001*) *(*Pt *711) 206*.

2.2.3 Limits of Autonomy

Notwithstanding its centrality, patient autonomy is not absolute. Certain limited exceptions exist where full disclosure or consent may be constrained.[23] These include situations of therapeutic privilege, where a patient lacks decision-making capacity, treatment of minors, public health necessity, and medical emergencies where immediate intervention is necessary to preserve life or prevent significant harm.[24] However, such exceptions must be narrowly construed and carefully regulated to prevent abuse because over-reliance on paternalistic justifications risks undermining the integrity of informed consent and eroding patient trust.

> *With specific reference to children or minors in Nigeria, different considerations actually apply in medical decision making.[25] Under international legal instruments, established provisions enable children to have access to medical treatment.[26] These provisions are replicated in the Childs Right Act, 2003 which is the legal framework for protection of the rights of a child in Nigeria. The Childs Rights Act provides for the right of every child to enjoy the best healthcare possible, and as a result, parents, guardians, and governments are collectively responsible for the for the care of the child, and are obliged to fulfil this right. As a result of this obligation, children rely on proxies (parents and guardians) to either consent to, or refuse treatment on their behalf due to their tender years and immaturity.[27] This means that where clear legal guidelines do not exist, parents or guardians alike could make unreasonable decisions that may have fatal effects on a child.*
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> *The case of Tega Esabunor and Anor v. Dr Tude Faweya and Ors[28] is an instructive one in this regard. Tega who was an infant, became critically ill and required urgent blood transfusion but his mother, a Jehovah's Witness, refused consent because her religious beliefs such forms of*

23 n.8.

24 *Sideway v Board of Governors of the Bethlem Royal Hospital (1985) AC 871.*

25 *Hadiza Okunrobo, Olaitan O. Olusegun, ''Balancing Parental Rights and Child Welfare: The Best Interests Treshold in Healthcare Decisions in Tega Esabunor and Anor v. Tunde Faweya and Ors. In Focus'', ABUAD Law Journal, (2024), Vol. 12, Issue 1, 65-83, <https://doi.org/10.53982/alj.2024.1201.04-j>*

26 *See for example, the United Nations Convention on the Rights of the Child (UNCRC), Art. 24(1); African Charter on the Rights and Welfare of the Child, Art. 14(1-2).*

27 n.25.

28 *(2019) LPELR 46961 (SC).*

treatment. Confronted with a life-threatening emergency, the attending medical doctor sought an ex-parte order from a Chief Magistrate authorizing the treatment through transfusion without the consent of the parent. The transfusion was successfully carried out and the child's life was saved. The mother challenged the legality of both the court and the medical treatment, and after losing at the lower courts, the case went to the Supreme Court. The issues for determination before the Supreme Court were:

a. *Whether a Magistrate had the jurisdiction to authorize emergency treatment for a child;*
b. *Whether the parent's constitutional right to freedom of religion and to make decisions for the child prevented the State from intervening;*
c. *Whether the emergency order and subsequent blood transfusion violated the rights of the appellant; and*
d. *Whether the appellants were entitled to damages.*

In dismissing the appeal and upholding the decisions of the lower courts, the Supreme Court held that where the life of a minor is in imminent danger, the State may intervene through the courts to authorize life-saving medical treatment despite the objections of parents based on religious beliefs. The Court also found that the Order of the Magistrate was lawful, and that the respondents were not entitled to damages. This case is of particular significance in Nigeria because it established that the best interests of the child are paramount, and that parental rights, including religious rights, are not absolute where the exercise of such rights would expose a child to serious harm or death. The case is also important in this discourse because it established that courts may exercise the State's parens patriae jurisdiction (the inherent protective power of the state) to safeguard children who cannot make medical decisions for themselves. It also established that medical practitioners who obtain lawful judicial authorisation for emergency treatment act within the law.

Consequently, any limitation on autonomy must be justified by compelling necessity and subject to clear legal boundaries.[29]

3. Doctrinal Analysis of The Legal Framework Governing Informed Consent In Nigeria

The doctrine of informed consent in Nigeria is best understood as a composite legal construct shaped by constitutional principles, judicial decisions, statutory provisions, and professional regulation. Although these sources collectively affirm patient autonomy as a central value in medical law, they do not form a fully integrated or codified framework. The Nigerian position reflects a developing system in which strong doctrinal recognition of consent coexists with incomplete operational and procedural guidance.

3.1 Constitutional Foundations

Although informed consent is not expressly provided for in the Constitution, it is implicitly grounded in a number of fundamental rights guaranteed under the Constitution of the Federal Republic of Nigeria 1999 (as altered) *that are discussed as follows:*

3.1.1 Dignity of the Human Person[30]

The right to dignity of the human person constitutes a fundamental norm in Nigerian constitutional law, and provides a critical doctrinal anchor for the theory and practice of informed consent in medical law. In principle, dignity is not only a rhetorical constitutional value, but a justiciable right that protects the intrinsic worth of every individual against practices that degrade, objectify, or instrumentalise the human person. In the healthcare context, this right operates as a constraint on medical paternalism, and as a positive obligation requiring that medical interventions respect the autonomy, bodily integrity, and decision-making capacity of patients. The decision in *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo*[31] is particularly significant, as the Supreme Court expressly linked medical treatment decisions to constitutional dignity, holding that a competent adult has the right to refuse medical treatment even where such refusal may result in death. This case situates dignity not as an abstract principle, but a fundamental legal foundation for patient autonomy and informed consent.

From a doctrinal perspective, dignity under section 34 performs three interrelated functions within informed consent jurisprudence. It serves as a

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29 *Airedale NHS Trust v Bland (1993) AC 789; Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo (2001) (Pt 711) 206.*

30 *Section 34.*

31 *Ibid*, 25.

substantive limitation on medical power, prohibiting coercive or non-consensual medical interventions except where justified by law, such as in emergencies or under statutory exceptions. It also operates as a structural principle of autonomy, requiring that patients are treated as rational agents capable of making informed decisions about their bodies, thereby rejecting the traditional paternalistic model in which physicians unilaterally determine what is in the patient's best interest. It further imposes a procedural obligation of respect, which manifests through the requirements of disclosure, comprehension, and voluntariness in informed consent. Consequently, dignity is doctrinally inseparable from the elements of informed consent, as each element functions to preserve the integrity of the person as a self-determining subject rather than a passive object of medical intervention.

Despite its strong constitutional formulation however, the doctrinal application of dignity in Nigeria remains uneven in medical practice. The persistence of hierarchical doctor–patient relationships and the discretionary nature of disclosure standards under the National Health Act, 2014 and MDCN guidelines indicate that dignity has not yet fully transformed clinical practice into a rights-based model. This gap reflects a broader doctrinal tension between constitutional rights-based norms and professional regulatory standards, where medical ethics often lag behind constitutional imperatives. While dignity theoretically demands patient-centred decision-making, in practice it is frequently mediated by professional judgment, socio-cultural deference, and structural inequalities in healthcare access and literacy.

Comparatively, the doctrinal evolution of dignity in Nigerian medical law remains at a transitional stage when measured against jurisdictions such as the United Kingdom, where dignity and autonomy have been judicially operationalised through cases like *Montgomery v Lanarkshire Health Board*. The doctrinal foundation laid in *Okonkwo*[32] has not yet been fully extended into a comprehensive jurisprudence of patient-centred disclosure and informed decision-making. This suggests that dignity in Nigerian medical law functions more as a prescriptive constitutional principle, rather than a fully operationalised doctrinal framework governing everyday clinical interactions. Consequently, despite the right to dignity of the human person under section 34 of the CFRN providing the constitutional backbone of informed consent in Nigeria, the full realisation of this doctrinal promise requires stronger integration between constitutional law, statutory regulation, and medical ethics to ensure that dignity is not only recognised in principle but consistently enforced in practice.

32 *Ibid*, 25.

3.1.2 Right to Privacy[33]

The right to privacy constitutes a central doctrinal pillar in the legal architecture of informed consent. It protects the sanctity of private life, including correspondence, communications, and personal data. Privacy in medical law is not limited to secrecy, it encompasses informational control, decisional autonomy, and protection from unauthorised intrusion into personal health matters. Within the framework of informed consent, privacy operates both as a substantive and procedural safeguard, ensuring that patients retain control over the disclosure and use of sensitive medical information and that medical decisions are made within a protected sphere of confidentiality.

In Nigerian medical jurisprudence, the connection between privacy and informed consent is most clearly reflected in the Supreme Court decision in *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo*,[34] where the Court emphasised that confidentiality and respect for patient autonomy are integral components of the doctor–patient relationship. The Court's reasoning implicitly situates privacy as a constitutional constraint on medical practice, reinforcing that patients must not only consent to treatment but must also have their personal medical information protected from unauthorised disclosure. This aligns privacy with the broader constitutional values of dignity under section 34, CFRN, creating a doctrinal triad of dignity, autonomy, and confidentiality that underpins informed consent.

From a standpoint of legal doctrine and structure, the right to privacy performs three key functions in informed consent. It establishes a confidentiality obligation, requiring healthcare providers to safeguard patient information except where disclosure is legally justified, such as in public health emergencies or court orders. It also supports informational autonomy, ensuring that patients control the flow of information about their medical condition and treatment decisions. Furthermore, it reinforces the integrity of the consent process, as meaningful consent presupposes a secure environment where patients can disclose sensitive information freely without fear of unauthorised exposure. These functions collectively demonstrate that privacy is not peripheral but foundational to the validity of informed consent.

However, the application of privacy in Nigeria reveals significant practical and regulatory gaps. While section 37, CFRN provides constitutional protection, there is limited statutory elaboration on data protection in healthcare settings, and the enforcement mechanisms remain fragmented. The National Health Act, 2014 and the MDCN Ethical Guidelines recognise confidentiality, but they do not provide a comprehensive framework for modern issues such as electronic health records, data sharing, or third-party

33 Section 37.
34 *Ibid* 25.

access to patient information. This creates a conflict between constitutional guarantees and regulatory insufficiency, leaving privacy protection heavily dependent on professional ethics rather than enforceable legal standards.

Comparatively, jurisdictions such as the United Kingdom have developed more robust doctrinal integration of privacy within medical law, particularly through case law and data protection regimes, while also balancing competing public interests. Nigeria, by contrast, remains in a transitional phase where privacy is constitutionally entrenched but not yet fully operationalised in healthcare governance. The implication for informed consent reform is that privacy must be re-conceptualised not merely as confidentiality in clinical interactions but as a comprehensive legal regime governing medical information, disclosure, and patient control over personal data.

It suffices to state therefore, that the right to privacy under section 37 CFRN provides a crucial doctrinal foundation for informed consent in Nigeria by protecting confidentiality, enabling informational autonomy, and safeguarding the integrity of the consent process. However, its full doctrinal potential remains underdeveloped due to limited statutory specificity and weak institutional enforcement. Strengthening this right within medical law requires clearer legislative frameworks, stronger regulatory oversight, and judicial engagement that aligns privacy with evolving standards of patient-centred healthcare and constitutional human rights protection.

3.1.3 Right to Life[35]

The right to life is the most fundamental of all constitutional rights and serves as the cornerstone of human rights protection within Nigerian law. It establishes both an obligation on the state not to unlawfully deprive life, and to take reasonable steps to protect life where it is at risk, particularly within healthcare systems. In the context of informed consent, the right to life does not operate in isolation. It interacts with the rights to dignity and privacy to create a complex legal framework in which life-preserving interventions must still respect individual autonomy and voluntary decision-making. This conflict is most clearly illustrated in medical scenarios involving refusal of treatment, end-of-life care, and emergency interventions.

The Supreme Court decision in *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo*[36] is central to understanding this relationship. The Court held that a competent adult patient has the right to refuse medical treatment, even where such refusal may result in death, thereby affirming that the right to life cannot be interpreted as a legal basis for compulsory medical intervention. This case clarifies that the right to life is not

35 *Section 33.*
36 *Ibid* 25.

absolute in a paternalistic sense because it does not empower medical professionals, or the state, to override informed refusal of treatment by a competent individual. Instead, it reinforces a rights-based equilibrium in which the preservation of life must be balanced against respect for autonomy, bodily integrity, and informed decision-making.

From a structural doctrinal perspective, the right to life in medical law performs three interrelated functions within the informed consent framework. It operates as a justification for medical intervention, particularly in emergency situations where consent cannot be obtained and immediate action is necessary to preserve life. It also functions as a limiting principle on state and institutional inaction, requiring healthcare systems to provide access to essential medical care in a manner that does not arbitrarily endanger life. Also, most significantly in the context of informed consent, it serves as a boundary condition for autonomy, ensuring that while patients may refuse treatment, such refusal must be informed, voluntary, and made with capacity, thereby preventing arbitrary or uninformed decisions that may undermine the legal and ethical value placed on life.

Nevertheless, conflicts arise in the Nigerian context due to the absence of detailed statutory guidance on how the right to life intersects with medical decision-making in borderline cases. The National Health Act, 2014 recognises consent as a prerequisite for treatment but provides limited elaboration on emergency exceptions and life-preserving interventions. This creates an interpretive space that often defaults to professional discretion, thereby reintroducing elements of medical paternalism. In practice, this means that the protection of life may sometimes be invoked to justify overriding or circumventing consent requirements. Comparatively, jurisdictions such as the United Kingdom have developed more refined doctrinal balancing through cases like *Montgomery v Lanarkshire Health Board*,[37] where autonomy and life-preservation are harmonised through a structured disclosure regime that prioritises patient understanding while recognising limited exceptions. Nigeria, by contrast, relies heavily on constitutional interpretation without a fully developed statutory or judicial framework that clearly delineates when life-preserving interests may override or justify limiting informed consent. This doctrinal gap underscores the need for clearer legal standards that define the scope of emergency treatment, refusal of care, and state obligations in protecting life without undermining autonomy.

Instructively, the right to life under section 33 CFRN occupies a central but complex position within the doctrine of informed consent in Nigeria. While it provides the justification for medical intervention and state protection of health, it must be read in harmony with the rights to dignity and privacy to

37 *Ibid* 14.

avoid unjustified paternalism. The jurisprudence in *Okonkwo*[38] establishes that life cannot be preserved at the expense of ignoring competent patient choice, thereby embedding autonomy within the constitutional protection of life itself. Nevertheless, relevant framework remains incomplete, requiring clearer statutory articulation and judicial development to ensure a consistent, rights-based balance between life preservation and informed consent in Nigerian medical law.

Collectively, these provisions establish a constitutional foundation for informed consent as a rights-based doctrine grounded in dignity, autonomy, and bodily integrity.

3.2 Judicial Development of Informed Consent Doctrine

3.2.1 Patient Autonomy and Refusal of Treatment

The most significant judicial authority is *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo.*[39] In this landmark case, the Supreme Court held that a competent adult patient has the right to refuse medical treatment, even where such refusal may result in death. The case firmly established that patient autonomy is legally enforceable in Nigeria, and that medical practitioners cannot override competent refusal. The case also established that informed consent includes the right to refuse treatment, and that paternalistic medical decision-making is legally constrained. *Okonkwo*[40] is therefore a cornerstone of Nigerian informed consent doctrine, marking a decisive shift from medical paternalism to autonomy-centred reasoning.

> *An important deviation from this principle was however enunciated in the aforementioned case of Tega Esabunor and Anor v. Dr Tude Faweya and Ors*[41] *where the Supreme Court stated explicitly that where a child is involved, the refusal of treatment cannot be exercised by a parent where such refusal would ultimately result in harm to a child.*

3.2.2 Consent as a Legal Precondition for Medical Intervention

In *Okekearu v Tanko*[42], the court reaffirmed that medical treatment without valid consent may amount to unlawful interference with the person. This case reinforces that consent is a legal prerequisite for lawful medical treatment, absence of which may ground liability in battery or negligence, and that

38 *Ibid* 25.
39 *(2001) 7 NWLR (Pt. 711) 206*.
40 *Ibid* 25.
41 *(2019) LPELR 46961 (SC).*
42 *(2002) 15 NWLR (Pt. 791) 657.*

medical intervention is not legally justified solely by professional competence. Together with *Okonkwo*[43], it confirms that consent is not only procedural, but fundamental to lawful medical practice. Contrasted with the case of *Tega Esabunor and Anor v. Dr Tude Faweya and Ors*[44] *however, the principle in this case is restricted by the fact that where a child is at the risk of harm, consent as a precondition for medical intervention can be dispensed with.*

3.3 Statutory Framework

The National Health Act, 2014 provides the most explicit statutory framework for informed consent in Nigeria and represents a significant legislative attempt to entrench patient autonomy within the healthcare system. The Act requires that 'a health care provider shall not administer any diagnostic, surgical or therapeutic procedure without the patient's informed consent', except in limited circumstances such as emergencies or where consent is given by a lawful surrogate.[45] By statutory implication, the Act adopts the central elements of informed consent, i.e. disclosure, understanding, voluntariness, and competence, thereby shifting Nigerian medical practice away from a purely paternalistic model towards one grounded in participatory decision-making. In the context of constitutional rights, particularly sections 34 *(the right to dignity of the human person)* and 37 *(the right to private and family life)* of the Constitution of the Federal Republic of Nigeria, 1999, the Act operationalises *constitutional provisions by ensuring* that patients retain control over decisions affecting their bodies and health information.

However, while the Act represents significant progress, its effectiveness is constrained by implementation gaps and conceptual ambiguities that weaken its rights-based orientation. The statutory exceptions, particularly 'emergency treatment' and 'surrogate consent', are broadly framed, leaving room for discretionary interpretation that may dilute patient autonomy in practice. Furthermore, the Act does not comprehensively define the standard of disclosure required, neither does it clearly resolve the conflict between professional-centred and patient-centred approaches to information sharing. As such, despite its rights-based aspirations, the National Health Act still operates within a transitional framework where elements of medical paternalism persist. In the context of informed consent reform therefore, the Act is an important, but incomplete step toward fully internalising patient autonomy within Nigerian healthcare law.

43 *Ibid* 25.
44 *Ibid* 41.
45 Section 23.

3.4 Regulatory and Professional Framework

The Medical and Dental Council of Nigeria (MDCN) plays a pivotal regulatory role in the governance of medical practice in Nigeria and is central to the enforcement of ethical and professional standards that underpin informed consent. Established by section 1 of the Medical and Dental Practitioners Act,[46] the MDCN is responsible for regulating the training, registration, and discipline of medical and dental practitioners.[47] In the context of informed consent, its ethical guidelines and disciplinary jurisdiction reinforce the duty of physicians to obtain valid consent before undertaking any medical intervention. This includes ensuring disclosure of relevant information, maintaining patient confidentiality, and upholding professional accountability. By setting standards of professional conduct, the MDCN operationalises the constitutional values of dignity and privacy in healthcare practice, thereby serving as a key institutional mechanism for protecting patient autonomy within Nigeria's medical system.

However, despite its regulatory importance, the MDCN framework reflects certain limitations that affect the full realisation of informed consent as a rights-based doctrine. Its ethical guidelines, while requiring consent, remain broadly framed, and do not always provide detailed procedural standards for disclosure or comprehension, leaving significant discretion to medical practitioners.[48] This can inadvertently sustain elements of medical paternalism, particularly in settings where hierarchical doctor–patient relationships persist. Furthermore, enforcement through disciplinary proceedings tends to be reactive rather than preventive, addressing breaches after harm has occurred rather than ensuring consistent compliance. In the broader context of legislative reform, this highlights the need for clearer statutory standards and stronger integration of patient-centred rights within MDCN regulations to ensure that informed consent is not merely a professional obligation but a fully enforceable legal right.

3.5 Synthesising the Current Position in Nigeria

The Nigerian legal framework on informed consent reflects a hybrid and transitional model characterised by strong judicial recognition of autonomy,[49] statutory acknowledgment,[50] ethical reinforcement, weak procedural and disclosure standardization, and limited enforcement mechanisms. This

46 Cap M8, LFN 20024.
47 Section 1(2).
48 Regulation 21.0, "The Code of Medical Ethics in Nigeria, 2008''.
49 *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo, (2001) 7 NWLR (Pt. 711) 206.*
50 National Health Act, 2014.

produces a system where informed consent is firmly recognised as a legal principle but remains inconsistently operationalised in clinical practice.
The doctrinal and legal framework of informed consent in Nigeria therefore demonstrates significant progress toward autonomy-based medical law. However, the absence of detailed disclosure standards and weak procedural codification reveal a gap between normative recognition and practical implementation. Accordingly, the doctrine of informed consent in Nigeria remains in an evolving state that is strong in principle, but still in need of structural refinement to achieve full effectiveness in healthcare governance.

4. Comparative Analysis

4.1 The United Kingdom (UK)

The United Kingdom offers one of the most instructive trajectories in the evolution of informed consent, moving from entrenched medical paternalism to a refined, autonomy-centred model grounded in judicial reasoning. Historically, the governing standard was the Bolam Test, established in *Bolam v Friern Hospital Management Committee*,[51] which held that a doctor is not negligent if acting in accordance with a responsible body of medical opinion. Applied to disclosure, this effectively meant that the scope of information given to patients was determined by professional practice rather than patient expectations. The result was a doctor-centred disclosure regime, where autonomy was secondary to clinical discretion and the physician's judgment of what was 'appropriate' for the patient to know.

This position was fundamentally transformed in *Montgomery v Lanarkshire Health Board*[52], where the UK Supreme Court decisively rejected Bolam as the standard for informed consent. The Court held that patients are entitled to be informed of material risks and reasonable alternatives, defined by what a reasonable person in the patient's position would consider significant. This case reoriented medical law around patient autonomy, dignity, and self-determination, aligning disclosure obligations with constitutional-style values rather than professional consensus. Significantly, the Court recognised limited exceptions such as therapeutic privilege and emergencies, thereby maintaining a structured but narrow space for clinical discretion.

A defining feature of the UK model is its judicial balancing approach. It does not make autonomy absolute, but integrates it into a context-sensitive framework that respects both patient rights and clinical realities. The emphasis on 'materiality' allows flexibility while ensuring accountability. For Nigeria,

51 *(1957) 1 WLR, 582.*
52 *(2015) UKSC, 11.*

this model demonstrates how courts can progressively constitutionalise informed consent without destabilising medical practice. It also shows the importance of aligning disclosure standards with constitutional rights under sections 34 and 37 of the CFRN, particularly dignity and privacy, thereby embedding autonomy within existing legal structures rather than treating it as an external ethical ideal.

4.2 The United States of America (USA)

The USA represents a tort-driven expansion of patient autonomy and material disclosure. It is an aggressive and litigation-centred development of the informed consent doctrine, rooted primarily in tort law rather than constitutional adjudication. The landmark case of *Canterbury v. Spence*[53] marked a decisive shift away from professional-centred standards. The Court held that the duty of disclosure is measured by the materiality of information to the patient's decision-making process, not by customary medical practice. This established the principle that a physician must disclose risks that a reasonable patient would consider significant in deciding whether to undergo treatment. The US approach therefore entrenches informed consent as a legally enforceable patient right, primarily through negligence litigation. Failure to disclose material risks gives rise to liability in tort, making courts central to enforcement. Unlike the UK's more doctrinally restrained evolution, the American model is heavily reliant on judicial enforcement after harm has occurred. Over time, this has led to a highly developed but fragmented body of case law, with variations across jurisdictions and increasing emphasis on defensive medicine, where practitioners over-disclose or over-test to avoid liability.

However, the US model also reveals structural limitations. While it strongly protects patient autonomy, it can produce over-legalisation of clinical practice, increased healthcare costs, and inconsistent application of standards. Fundamentally, because enforcement is retrospective (through litigation), it does not always prevent breaches of informed consent at the point of care. For Nigeria, this highlights the danger of relying solely on court-driven enforcement without strong regulatory and statutory frameworks. It also underscores the need for clear, prospective standards under bodies like the MDCN and legislation such as the National Health Act, 2014.

4.3 Comparative Insights and Lessons for Nigeria

A comparative reading of both jurisdictions reveals a shared trajectory of a gradual but firm rejection of medical paternalism in favour of patient-centred autonomy, although differing in method. The United Kingdom achieves

53 *(1972) 464 F.2d 772.*

reform through judicial evolution and doctrinal recalibration, balancing autonomy with clinical practicality. The United States achieves similar outcomes through tort-based enforcement, prioritising patient rights but at the cost of procedural complexity and litigation dependency. Instructive to Nigeria, these systems offer complementary lessons.

The UK model suggests that Nigerian courts can progressively interpret informed consent in line with constitutional guarantees of dignity and privacy, as already signalled in *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo*.[54] The American model clearly demonstrates the importance of enforceability but warns against excessive reliance on litigation as the primary enforcement mechanism. Also, both systems underscore the necessity of a clear patient-centred disclosure standard, which Nigeria currently lacks in precise statutory form. Instructively, Nigeria's reform path should integrate these insights into a hybrid framework of constitutionally grounded judicial interpretation, strengthened statutory codification under the National Health Act, and more detailed MDCN guidelines that operationalise disclosure, comprehension, and voluntariness. Such an approach would ensure that informed consent is not only a procedural requirement, but a substantive constitutional right anchored in autonomy, dignity, and privacy, while remaining sensitive to Nigeria's clinical and institutional realities.

5. Findings, Recommendations, And Conclusion

5.1 Key Findings

This study reveals a system in Nigeria that is in transition, situated between traditional medical paternalism, and an emerging rights-based model anchored in constitutionalism and modern medical ethics.

The first finding of this paper is that, although informed consent is formally recognised under the National Health Act, 2014 and reinforced by professional ethical rules of the Medical and Dental Council of Nigeria (MDCN), its practical implementation remains uneven and conceptually underdeveloped. In practice, disclosure standards are still largely shaped by professional discretion rather than a clearly articulated patient-centred benchmark, resulting in significant variability in clinical practice.

A second finding of the paper is that Nigerian courts have begun to affirm autonomy as a constitutional value, particularly through the decision in *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo*,[55] which recognised a competent patient's right to refuse treatment. However, this judicial recognition has not yet matured into a consistent doctrinal framework

54 *(2001) 7 NWLR (Pt. 711) 206.*
55 *(2001) 7 NWLR (Pt 711) 206.*

on informed consent when compared to developments in jurisdictions such as the United Kingdom and the United States. As a result, gaps still remain between constitutional ideals of dignity and privacy and the operational realities of medical practice.

The paper also finds that inadequate patient education and awareness significantly hinders the ability of patients to understand their rights and participate meaningfully in medical decision-making.

A further finding of this study is that institutional regulation, particularly through the MDCN, provides ethical guidance but lacks detailed procedural clarity on key elements of informed consent such as disclosure thresholds, comprehension standards, and documentation requirements. This regulatory ambiguity allows paternalistic practices to persist, especially in high-pressure clinical environments where patient participation in decision-making may be limited by socio-economic, educational, and linguistic factors.

5.2 Recommendations

With specific reference to its first finding, this paper recommends a need for statutory clarification and reform of the National Health Act, 2014 to provide a more detailed and operational definition of informed consent. *This would impose a clear statutory duty on healthcare providers to obtain informed, not merely voluntary consent, and establish effective enforcement mechanisms and sanctions for non-compliance.* This should explicitly incorporate a patient-centred standard of disclosure, as *was gleaned from the experience in the United Kingdom and the United States of America as revealed in this paper*. *This would include* requirements for material risk communication, explanation of alternatives, and assurance of comprehension in linguistically and culturally appropriate forms.

> *With reference to the second finding of this paper, it is recommended that the National Health Act, 2014 is amended to incorporate relevant judicial decisions that have had direct implication on the issue of informed consent in Nigerian healthcare. This would entail the Act specifically stating things such as the rights of an adult to refuse treatment as was held in the Okonkwo[56] case, or the exceptions to consent as it relates to a child who naturally does not possess the legal capacity to give consent, as was held in the Tega[57] case. Such a reform would reduce excessive reliance on litigation as the primary enforcement mechanism.*

56 *Ibid* 55.
57 *Ibid* 41.

> *Regarding the third finding of this paper, it is recommended that public health policies in Nigeria prioritises patient education and awareness in order to let individuals understand their rights and limitations, and to also enhance their active participation in medical decision-making.*

The paper also recommends that the Medical and Dental Council of Nigeria (MDCN) should revise its ethical guidelines to include structured protocols for obtaining and documenting informed consent. This should move beyond general ethical exhortations to provide clear, enforceable standards aligned with constitutional rights to dignity and privacy. *Such a reform would ensure that informed consent is not merely a professional obligation but a fully enforceable legal right, and also strengthen patient's rights, improve accountability within the healthcare system, while promoting respect for individual accountability.*
Without these, legal reforms alone will have limited practical impact.

5.3 Conclusion

Informed consent in Nigeria occupies a critical but underdeveloped position at the intersection of constitutional law, medical ethics, and healthcare regulation. While significant progress has been made through statutory recognition and judicial affirmation, the doctrine remains inconsistently applied and structurally constrained by paternalistic traditions and regulatory ambiguity. Comparative analysis demonstrates that both the United Kingdom and the United States have developed more coherent patient-centred frameworks, though through different mechanisms of judicial evolution in the UK and tort-based enforcement in the US.

The Nigerian experience therefore reflects a transitional legal order where autonomy is recognised in principle but not fully operationalised in practice. To bridge this gap, Nigeria must engage in comprehensive reforms in line with the foregoing recommendations.