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THE EMERGENCE OF BLOODLESS MEDICINE AND SURGERY IN THE TREATMENT OF PATIENTS: MEDICO-LEGAL ISSUES ARISING THEREFROM

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ABSTRACT

Bloodless medicine and surgery refers to the treatment and care of patients medical and surgical needs without the use of allogeneic blood and blood products. It is an alternative to blood transfusion and has become increasingly attractive due to its benefits which include; minimising the infections associated with blood transfusion and improving patients' recovery. The emergence of this evolving branch of medicine raises certain medico-legal issues revolving around the liabilities of doctors who opt for bloodless medicine and surgery in the treatment of patients, and the issue of consent of adult patients, minors, mentally disordered patients and unconscious patients in emergency situations. This work examines these medico-legal issues with a view to sensitising the judiciary, legal practitioners, doctors and the populace on the legal obligations, implications and liabilities arising from bloodless medicine and surgery. This work adopts the doctrinal method of research, which involves the use of primary and secondary sources of law. This work finds that doctors are not liable for the sole act of adopting bloodless medicine and surgery over blood transfusion in the treatment of patients in the absence of negligence or treatment without valid consent. It also finds that the use of exparte applications by the state in seeking an order for a desired form of treatment for incompetent patients is not in the spirit of fair hearing and precludes the other party from advancing evidence on his or preferred form of treatment. This work suggests that the use of exparte applications by the state should be discouraged. It also recommends that due to the expeditious nature of cases involving conflicts between the state and parents or guardians of incompetent patients, family courts should be established in each state of the federation for speedy dispensation of justice.

Keywords: Bloodless medicine and surgery, consent, minors, mentally disordered patients, unconscious patients.

INTRODUCTION

The therapeutic use of blood can be traced to early Egyptian writings dating back at least 2,000 years ago, suggesting oral ingestion of blood as a remedy for leprosy and the use of human blood to treat epilepsy.[1] Medical science over the years has developed to include blood transfusion as a therapeutic use of blood in the treatment of anemic patients, invasive procedures and other health related complications. The use of blood in the treatment of patients carries with it uncommon but potentially fatal complications, multiple factors besides fear of infectious and non-infectious complications have contributed to the paradigm shift away from the liberal use of transfusions in clinical medicine to a safer management of patients without allogeneic blood products.[2]

Bloodless medicine refers to emerging clinical strategies for medical care without allogeneic blood transfusion and is a well-defined area in blood management.[3]Bloodless medicine may be adopted in a number of clinical settings; when patients object to transfusion for safety or for religious reasons, when blood may be in short supply or not available, or when safe (screened and tested) blood is not available.[4] Bloodless medicine has been viewed by many patients not as a last resort but as a preferred treatment, as an alternative to blood transfusion. Increasing number of patients today refuse transfusions out of fear of blood-borne diseases such as AIDS and hepatitis, not to mention unidentified viruses.[5] Other factors make bloodless medicine and surgery increasingly attractive, for example, compatible blood transfusion may be unobtainable for patients with multiple antibodies.[6] Some of the recommendations by the WHO to the risks of transmission of serious infections through unsafe blood are the rational use of blood and blood products to reduce unnecessary transfusions and minimise the risks associated with transfusion, the use of alternatives to transfusion where possible.[7] As recommended by the WHO one of the foremost alternatives to transfusion is bloodless medicine and surgery.

The use of bloodless medicine and surgery in the treatment of patients is not devoid of legal obligations and implications as well as ethical duties and professional liabilities. This work focuses on the medico-legal issues arising from the use of bloodless medicine and surgery in the treatment of patients and the issues of consent relating to patient's choice in their acceptance or refusal of treatments with allogeneic blood. It also examines factors affecting valid consent, such as capacity or competence of patients to consent to or refuse treatments, for example, in the case of minors, mentally disordered patients and unconscious patients in emergency situations.

ISSUE OF LIABILITY IN THE USE OF BLOODLESS MEDICINE AND SURGERY AS A FORM OF TREATMENT.

It is imperative to look at the liability or otherwise of doctors in their choice of bloodless medicine and surgery over blood transfusion in the treatment of patients. Medical malpractice suits emanating from negligence claims involve the existence of a duty of care owed by doctors to their patients, breach of that duty and injury resulting from such breach.

[1]D Savarese and others, 'Bloodless Medicine and Surgery' *Journal of Intensive Care Medicine*(1999) (14) (1) 20.
[2] ibid20,21.
[3] LT Goodnough, A Shander and R Spence 'Bloodless Medicine: Clinical Care Without Allogeneic Blood Transfusion' *Transfusion* (2003) (43) (5) 668.
[4] ibid.
[5] ibid.
[6] ibid.
[7]<https://www.who.int/news-room/fact-sheets/detail/blood-safety-and-availability> accessed on 31 May 2022.

Doctors in avoiding malpractice suits must understand the standard by which breach of their duty will be judged. In tort generally standard of care is determined by the standard of the 'reasonable man' test or principle.

The standard of care expected of a skilled medical doctor is the standard of a reasonable medical practitioner exercising and professing to have that special skill.[8] The implied duty of reasonable care created by the doctor-patient relationship is breached when doctors do not measure up to the required standard of care of medical practice. Doctors are not negligent or liable for the singular act of preferring or opting for an alternative form of treatment different from the acceptable standard of practice. As Lord Clyde cogently points out in *Hunter v Hanley*:[9]

> In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion. One man is not negligent merely because his conclusion differs from that of other professional men…Deviation from ordinary professional practice is not necessarily evidence of negligence and it would hinder progress in medical treatment if the law were to hold otherwise.

The above decision was reinforced by the decision of the court in *Bolam v Friern Hospital Management Committee*[10]where the 'Bolam test' which has become the accepted rule for assessing what the appropriate standard of care should be in cases of medical negligence was propounded. On the issue of standard of care determined by approved medical practice, albeit divergent practices and opinions McNair J resolved thus:

> A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular act…Putting it the other way round, a doctor is not negligent if he is acting in accordance with such a practice merely because there is a body of opinion that takes a contrary view. At the same time that does not mean that a medical man can obstinately and pig-headedly carry on with some old technique if it had been proved to be contrary to 'enforced medical opinion'.

Medical advances over the years since Hippocrates have at some point been a departure from the normal and accepted practice, and to label such departure as of its nature negligence is a dangerous nonsense.[11] In medicine, as in other professions, practice standards evolve over time, and while the courts will have regard to common practice in medicine in determining the issue of negligence, they will not be bound to accept that evidence in all cases as conclusive, it is safe to say that the courts will have recourse to common medical practice to set the standard of care and enforce same depending on the circumstances of each case, thus having the final say as to the legal acceptability of a medical practice.[12]

Having established the fact that a departure from a normal and accepted medical practice is in itself not negligence so long as the departure is accepted as proper by a responsible body of medical men versed in that school of thought, it is right to say that doctors who opt for bloodless medicine and surgery in the treatment of patients as opposed to the normal practice of blood transfusion will not be liable in negligence simply because of

[8]*Clark v Maclennan* (1954) 2Q.B. 66.
[9]1955 SC 200.
[10][1957] 1 WLR 582.
[11] KMNorrie, 'Medical Negligence: Who Sets the standard?' *Journal of Medical Ethics*(1985) (11) 136.
[12]ibid, 137.

their choice. This is because bloodless medicine and surgery is a branch of medicine that is widely gaining acceptance based on reasonable grounds. Integral to bloodless surgery is a coordinated peri-operative disciplinary multimodal approach.[13]It is a rational approach backed by scientific support and its reasonableness is based on the numerous fatal risks of blood transfusion and the fact that it is safer, cost effective and improves the quality of patients care.[14]

The fact that bloodless medicine is a developing discipline and a departure from the common practice of blood transfusion does not exculpate doctors who undertake bloodless procedures from liabilities if such procedures are devoid of reasonable care and skill. In order to establish liability in circumstances where deviation from normal practice is alleged, Lord Clyde in *Hunter v Hanley*[15] laid down three requirements that had to be established:

1. It must be proved that there is a usual and normal practice;
2. It must be proved that the defender has not adopted that practice; and
3. Most importantly, it must be established that the course the doctor adopted is one that no professional man of ordinary skill would have taken if he had been acting with ordinary care.

If the chosen course of treatment, whether the common practice or it departure, is performed negligently, the doctor would be liable to damages. However, as Neill L.J held in *Thake v Maurice*[16] that in considering the liability of a medical practitioner at any point in time, the court must consider whether he acted with due diligence having regard to the facts and circumstances of the case. The fact that an injury or fatality occurs despite due diligence by a doctor is not conclusive proof of malpractice. Lord Denning in *Hatcher v Black*[17] held thus:

> It would be wrong and indeed bad law, to say that simply because a misadventure or mishap occurred, the hospitals and the doctors are thereby liable. It would mean that a doctor examining a patient, or a surgeon operating at a table, instead of getting on with his work, would be forever looking over his shoulder to see if someone was coming up with a dagger-for an action for negligence against a doctor is for him like unto a dagger. You must not, therefore, find him negligent simply because something happens to go wrong; if, for instance, one of the risks inherent in an operation actually takes place or some complication ensues which lessens or takes away the benefits that were hoped for, or if in a matter of opinion he makes an error of judgment, you should only find him guilty of negligence when he falls short of the standard of a reasonably skillful medical man…

The 'Bolam test' of acceptance of a practice on the ground of sanction by a responsible body of medical opinion based on reasonable grounds was clarified by the House of Lords in *Bolitho v City & Hackney Health Authority*.[18] The case concerned the death of Patrick a two-year old child suffering from breathing difficulties where a doctor failed to

[13]V Martyn and others, 'The Theory and Practice of Blood Surgery' *Transfusion and Apheresis Science*(2002) (27) 30.
[14] ibid.
[15] (n9).
[16](1986) 2 WLR 337.
[17](1954) 4 All ER 118.
[18][1997] 3 WLR 1151.

attend to him due to a malfunctioning bleeper. The defendant contended that if she had attended to Patrick she would not have intubated him because according to her it was not necessary for a young patient as the procedure itself carries a certain degree of mortality and morbidity. The plaintiff's expert medical witnesses contended that she should have intubated him as this would have protected his airway and thus saved his life. One of the issues at the Court of Appeal was for the courts to decide the appropriate standard of care. The House of Lords affirming the decision of the trial court on the issue of standard of care held that:

> In determining what represents a responsible body of medical opinion, the court is not bound to follow expert evidence led by the defendant physician. It must be satisfied that that respectable body of medical evidence has a 'logical basis', which requires the court to ensure that the experts 'had directed their minds to the question of comparative risks and benefits and reached a defensible conclusion on the matter.

From the above decision it should be understood that a departure from the common practice has to be logical, and when weighed with the common standard of practice as to the comparative risks and benefits, it must not only outweigh it but must also reach a defensible conclusion. The preference of bloodless medicine and surgery over blood transfusion in developed countries should also be welcomed in other parts of the globe. As observed by Spence 'The once – simple act of ordering and transfusing blood with impunity has become a complex decision-making process involving consideration of risks, physiologic variables, alternatives, and patient preferences.[19] These changes have left many physicians uncertain about the appropriate use of red blood cell (RBC) transfusions in the surgical patient.[20]

Doctors cannot claim ignorance of this developing trend to escape liability because articles describing the emerging risks involved in the use of allogeneic blood are appearing in medical journals with some regularity.[21] The implication of such ignorance is disastrous for erring doctors as was the case for Dr. Engle in *Burton v Brooklyn*,[22] where the court held that although the conventional medical wisdom at the time believed that increased oxygen was essential to the survival of premature babies, the hospital and Dr. Engle cannot avail themselves of the shield of acceptable practice when a number of studies, including their own, had already indicated that increased oxygen was both unnecessary and dangerous, Dr Engle and the hospital were held liable to damages.

Clay advises doctors to update their understanding of the risks and benefits of allogeneic blood by attending CME sessions devoted to the topic, read relevant review articles, consensus papers, practice guidelines, and conference reports.[23]Doctors are also advised to keep current with advances in bloodless medicine, as these advances change the standard of care and as such doctors who practice according to what was once 'acceptable practice' will not automatically be freed from liability.[24] Doctors might also consider

[19] RK Spence, 'Surgical Red Blood Cell Transfusion Practice Polices' *American Journal of Surgery* (1995) (170) 3-15.
[20] ibid.
[21]MA Clay, 'Ethical and Legal implications of Bloodless Medicine and Surgery' *Journal of Intensive Care Medicine*(1999) (14) (1) 37.
[22]88 A.D.2d 217 (N.Y. App. Div. 1982).
[23]Clay(n21) 37.
[24]ibid, 39.

developing patient education and sensitisation materials that answer commonly asked questions and explain some of the known risks of blood transfusion.[25]

RIGHT OF COMPETENT ADULTS TO REFUSE TREATMENT WITH ALLOGENEIC BLOOD

Informed consent in a healthcare setting is the procedure whereby patients consent to or refuse treatment based on information provided by a healthcare professional regarding the nature and potential risks, consequence and likelihood of a treatment.[26] Consent is required mostly in serious medical procedures such as invasive surgical and diagnostic procedures. According to Dada consent entails the dual ingredient of awareness and assent.[27] This means that the doctor must have informed the patient about the inherent risks, benefits and consequences of the procedure and the patient must have given authorisation or consent to the procedure. Consent is valid only if it is informed, such that any consent given without adequate information as to the pros and cons of a procedure will be invalid.

The right to informed consent is guaranteed by the right to privacy under the Constitution of the Federal Republic of Nigeria 1999 (as amended),[28] the right to sanctity and dignity of human person[29], and right to religious liberty.[30] Informed consent is hinged on the right of a patient to be informed about the condition, treatment options available and possible effects and side effects of the outcome of a proposed treatment.[31] The right to informed consent has been recognised in a number of cases. In *Sidaway v Board of Governors of the Bethlehem Royal Hospital,*[32] Lord Templeman held that:

> A patient is free to decide whether or not to submit to treatment recommended by the doctor …if the doctor making a balanced judgment advises the patient to submit to the operation, the patient is entitled to reject the advice for reasons which are rational or irrational.

The court further held that it will not allow medical opinion of what is best for the patient to override the patient's right to decide for himself whether he will submit to the treatment offered him.

In the Nigerian case of *Okonkwo v MDPDT*,[33] the Supreme Court also recognised the right of a patient to informed consent when it held that:

> The patient's consent is paramount…(Accordingly), the patient's relationship (with a doctor) is based on consensus, it follows (sic) 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.

[25]ibid, 37.
[26]MO Aguda, 'An Overview of a Patient's Right with Regards to Informed Consent to Treatment and the Right to Refuse Treatment: A Model for Medical Healthcare in Nigeria' *Nigerian Institute of Advanced Legal Studies Journal of Health Law and Policy Maiden Edition*77.
[27]JA Dada, *Legal Aspect of Medical Practice in Nigeria,* 2nd edn (University of Calabar Press, 2013)122.
[28]s 37 CFRN 1999.
[29]s 34 CFRN 1999; r 9(a) Code of Medical Ethics 2004 (CME).
[30]s 38 CFRN 1999.
[31]Patients' Bill of Rights 2018.
[32][1985] AC 871.
[33](2001) LPELR-1856 (SC).

The above decisions recognise the patient's autonomy and basic human right in determining what should or should not happen to his body and his right to gather enough information from a medical doctor before undergoing a surgery, test or clinical procedure. Thus, guaranteeing his right to accept or refuse treatment with allogeneic blood, while opting for bloodless medicine and surgery.

Performing an invasive or non-invasive procedure, diagnosis or treatment, without a patient's consent is battery, an intentional tort, which exposes a doctor to civil liability. Battery is the intentional application of force to a person without lawful justification and which results in harm.[34]It is battery for a medical doctor to amputate any part of a patient's body without the patient's consent. In *Mohr v Williams*,[35] the surgeon obtained the patient's consent to operate on the right ear. During the operation, the doctor discovered for the first time, that the left ear was in worse condition than the right. Without first obtaining the consent of the patient, he operated on the left ear also. The plaintiff instituted an action against the surgeon for assault and battery. It was held that a touching is unlawful if it is unauthorised regardless of the defendant's intent. The surgeon was held liable for battery.

The evolving practice of bloodless medicine and surgery is to the effect that a doctor who overrides a competent patient's refusal of allogeneic blood or blood products has breached his/her duty not to interfere with the patient's autonomous choice and is therefore open to malpractice charges should injury be caused by his/her decision.[36] Conversely, a doctor who without consent or who overrides a competent patient's choice of blood transfusion and goes ahead to administer bloodless medicine and surgery treatment would be guilty of having breached his/her professional duty opening himself/herself to battery claims if injury occurs.

When a doctor obtains a patient's consent, but fails to make appropriate disclosures including risks and benefits of the procedure such that the consent was not informed he/she would be liable in negligence. Doctors who offer to use bloodless medicine and surgery in the treatment of patients who consent to such treatment are obligated to provide relevant and material information regarding the nature, risks, benefits, and consequences of the proposed treatment. In Nigeria the National Health Act (NHA)[37] provides that every medical practitioner shall give a patient relevant information pertaining to his state of health and necessary treatment relating to:

a) the patient's health status except in circumstances where there is substantial evidence that the disclosure of the patient's health status would be contrary to the best interests of the patient;
b) the range of diagnostic procedure and treatment options generally available to the patient;
c) the benefits, risks, costs and consequences generally associated with each option; and
d) the patient's right to refuse health services and explain the implications, risks or obligations of such refusal.[38]

The test of materiality in determining the amount of information to be disclosed by a medical doctor to a patient regarding the risks and consequences of a procedure was laid

[34] DU Odigie, *Law of Tort: Text and Cases* (Ambik Press Ltd 2008) 12.
[35](1905) 95 Minn 261, 104 N W.
[36]Clay(n21) 36.
[37] No 8, 2014.
[38]s 23 NHA 2014.

down in *Montgomery v Lanarkshire Health Board*[39]by Lord Kerr and Lord Reed 'The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it'. In that case Nadine Montgomery gave birth to a baby boy at Bellshill Maternity Hospital, Lanarkshire. As a result of complications during the delivery, the baby was born with severe disabilities. Mrs Montgomery filed an action seeking damages on behalf of her son for the injuries he sustained due to the negligence on the part of Dr Dina McLellan, a consultant obstetrician and gynecologist who was responsible for Montgomery's care during her pregnancy and labour. On the first issue bordering on consent it was contended that she ought to have been given advice about the risk of shoulder dystocia (the inability of the baby's shoulders to pass through the pelvic) which would be involved in vaginal birth, and of the alternative possibility of delivery by elective caesarean section. The Supreme Court of England held that:

> If (1) the patient suffers damage, (2) as a result of an undisclosed risk, (3) which would have been disclosed by a doctor exercising reasonable care to respect her patient's right to decide whether to incur the risk, and (4) the patient would have avoided the injury if the risk had been disclosed, then the patient will in principle have a cause of action based on negligence.

The court further held that a doctor is under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative treatments. A doctor is however, entitled to withhold from the patient information as to a risk if he reasonably considers that its disclosure would be seriously detrimental to the patient's health as well as in circumstances of necessity. The Supreme Court thus found that Dr McLellan had breached her duty of care and was negligent.

THE USE OF BLOODLESS MEDICINE AND SURGERY IN TREATMENT OF INCOMPETENT/INCAPACITATED PATIENTS

Capacity refers to 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.[40] A patient has the capacity to consent to a treatment or procedure if he has the ability to understand the nature of the procedure and can communicate his decision. A person lacks capacity if his mind is impaired or disturbed in some way, making him unable to make a decision. This work focuses on three of such instances where a patient lacks capacity – (i) minors (ii) mentally disordered persons and (iii) unconscious patients in emergency situations.

i) Minors

A minor is 'a person who has not reached full legal age; a child or juvenile'.[41]The age of maturity varies from country to country. A child is defined as a person who is under the age of eighteen (18) years.[42] Children are prohibited from entering into contracts, except contract for necessaries.[43]It is a general rule that a competent adult is entitled to consent to or reject a form of treatment; this rule has little direct application to children. Dada is of the opinion that consent to examination and treatment is not dependent on the attainment of the

[39][2015] UKSC 11.
[40]BA Garner, *Black's Law Dictionary,* (7th edn, West Publishing Co 1999) 220.
[41]ibid,1017.
[42]s 277 Child's Right Act (CRA) 2003.
[43]s 18 CRA 2003.

age of majority.[44]Skegg is of the view that the common law principle that all minors are incapable of consenting to medical procedures is a fundamental misconception of the position of such procedures in relation to criminal and civil law.[45]

Consent to medical treatments is not determined by the age of the patient simpliciter but sufficient understanding by the individual, the notion of capacity turns largely on the question of understanding.[46] This principle known as the 'mature minor' rule was judicially recognised in the English case of *Gillick v West Norfolk and Wisbech Area Health Authority*.[47] In that case, the House of Lords decided that a 16 year old girl who apparently is below the age of maturity is competent to consent to and receive contraceptive advice and treatment notwithstanding parental objections, provided it is established that he or she fully understands the nature and purpose of the medical treatment proposed.

A 'Gillick competent minor' who is mature enough and knowledgeable to understand the nature of a proposed medical treatment, its risks, benefits and consequences, is entitled to the right of consent to medical treatment irrespective of his/her age or the will of his parent. A medical doctor who performs a medical procedure on a minor who is capable of giving consent without his consent first had and obtained will be liable for battery. Similarly, a doctor who obtains consent from the parents or guardians of a Gillick competent minor capable of giving consent instead of the minor will in the same vein be liable for battery. This was the position of the Supreme Court in *Okekearu v Tanko*,[48] where the defendant a medical doctor amputated the finger of the plaintiff, a 14 year old boy without his consent, the Supreme Court found the medical doctor liable for battery notwithstanding the alleged consent of the plaintiff's/respondent's aunt. The Supreme Court stated as follows:

> It is clear from the above that Tanko's consent was not sought. It was the consent of Tanko's aunt which was sought. Did Tanko lack legal capacity to give his consent? Was Tanko in state of coma that he was not in a position to give his consent? Why was consent not directly procured from Tanko? He was…fourteen years when his finger was amputated. In the absence of any medical evidence that Tanko lacked the capacity of giving his consent to the amputation of his finger, I cannot see the justification of ignoring him to obtain the consent of PW2, his aunt.

Medical doctors should carry out capacity assessment in order to determine the capacity of minors to give informed consent in exculpating themselves from liability in trespass for lack of consent. The litmus test for determining capacity need not be restricted to the age of minors as knowledge is not dependent on age but the ability of the minor to understand the nature of the proposed treatment and his mental maturity to make rational choices and willingness to consent to treatment.

'Decisionally incapable minors' are minors that are incapable of making decisions. These categories of minors are incapable of giving consent to medical treatment. Decisionally incapable children may be said to be children below the age of seven who lack intellectual

[44]Dada(n27) 222.
[45] PDG Skegg, *Law, Ethics and Medicine: Studies in Medical Law* (Clarendon Press 1984) 512.
[46]FO Emiri, *Medical Law and Ethics in Nigeria* (Malthouse Press Limited, 2012)328.
[47][1985] 3 All ER 402.
[48][2002] 15 NWLR (Pt 791) 657

maturity to make rational choices.[49] It is safe to say that 'decisionally incapable minors' are minors who lack the capacity to give informed consent either because of their tender age or inability to understand the complexity involved in the nature of a proposed treatment. Consent obtained from such decisionally incapable minors will be invalid and may attach liability for battery if a doctor relies on such consent to go ahead with a proposed medical treatment. In such cases, parents or other surrogate decision-makers may give informed permission or consent for diagnosis or treatment of the minor.[50]

Parents or guardians of such incapable and incompetent minors are empowered to give informed permission or consent relating to the health care of such minors. The decision of the parent or guardian in this instance should be respected, although it is not absolute, based on the following reasons. First, since parents care about the welfare of their children, they will usually be in a better position than others to understand the unique needs of their children, desire what is best for their children, and make decisions that are beneficial to their children. Second, parents should be permitted to raise their children according to their own standards, beliefs, values and to transmit same to their children. Lastly, in order for family relationships and unity to flourish, the family must have sufficient space and freedom from intrusion by others.[51]

Parental decision-making capacity for incompetent minors is not absolute, when a parent or guardian acts contrary to the best interest of a child, the state may intervene.[52] This principle is based on the doctrine of *parens patriae* which allows the state to step in and serve as a guardian for children, the mentally ill, the incompetent, the elderly, or disable persons who are unable to care for themselves. The state through the judicial mechanism of the courts can invoke the doctrine of *parens patriae* to make decisions bordering on the welfare of a minor as long as it is in the child's best interest.

In a situation where a parent refuses a particular mode of treatment necessary for the well-being of a child, likely to pose some harm to the child, the court can assume temporary guardianship or custody for the purpose of authorising medical care under the claim of medical neglect. The case of *Esabunor v Faweya*[53] is instructive on this point. In that case, the 1st appellant, a child of one month was rushed to the Chevron Clinic by his mother the 2nd appellant. Dr. Faweya, the 1st respondent, examined him and found that the child was suffering from severe infection and anemia. The next morning Dr. Faweya observed that the child was in a very bad shape and it became increasingly obvious to him that the child desperately needed a blood transfusion to remain alive. The child's mother bluntly refused blood transfusion for her child. She made it clear that because of her religious beliefs, being a Jehovah's Witness she cannot consent to her child receiving blood.

The apex court held that when a competent parent or one in *loco parentis* refuses blood transfusion or medical treatment for her child on religious grounds, the court should step in, consider the baby's welfare which is saving the life and the best interest of the child, before a decision is taken. These considerations outweigh religious beliefs of the Jehovah's Witness. The decision should be to allow the administration of blood transfusion especially in life threatening situations. The Court went further to hold that in the light of children

[49]Dada(n27) 222-223.
[50]Aguda(n26) 81.
[51] DS Diekema, 'Parental Refusals of Medical Treatment: The Harm Principle as Threshold for State Intervention' (2004) (25) (4) *Theoretical Medicine and Bioethics,* 243-264.
[52]LF Ross, *Children, Families, and Health Care Decision-Making* (Oxford University Press 1998) 135.
[53](2019) LPELR – 46961 (SC).

protection laws, that is, the Child Rights Act, particularly sections 13 and 59(a), it could have amounted to a great injustice to the child if the court had stood by and watched the child being denied of basic treatment to save his life on the basis of the religious conviction of his parent. In life threatening situations such as the 1st appellant was in as a child the consideration to save his life by application of blood transfusion greatly outweighs whatever religious beliefs one may hold, especially where the patient is a child.

The decision of the court is instructive and logical. However, intervention from the courts ought only to be regarded as the exception rather than the rule, and there should be a genuine reluctance to interfere with the reasonably held views of parents.[54] Where a court is considering whether or not to make an order under the Child Rights Act with respect to the treatment of a child, it cannot make such order unless it considers that doing so in the circumstance would be better for the child than making no order at all.

While it is binding law that the courts will authorise a necessary blood transfusion for a minor over his/her parents refusal on religious grounds if it is in the best interest of the child it is unlikely that the court will order same if the parent's decision regarding the type of medical treatment for his/her child, whether it is an alternative form of treatment or no treatment at all, is in the child's best interest. In line with the 'best interest principle' the state can only intervene to order a blood transfusion when it can demonstrate a convincing countervailing interest. The advantage of the 'best interest principle' is that it is a flexible mechanism that can be used by the courts in a variety of different ways to justify a decision, the courts enjoy a wide margin of appreciation where, on the one hand, they can view the principle in a narrow sense to justify a particular outcome and, on the other, they can view it from a much wider perspective in order to support a different decision.[55]

When presented with a case where parents have refused to consent to medical treatment for their child, courts generally apply a balancing test. In *Newmark v Williams,*[56] the Delaware Supreme Court held that the state Division of Child Protective Services (DCPS) should not have custody of a 3 year old boy in order to authorise chemotherapy that his Christian Science parents had rejected on religious grounds. The child's doctors claimed that without treatment the boy would die within 6 to 8 months. The court held that because the treatment would be painful, risky, toxic and life threatening with a less than 40 percent likelihood of success, it was not negligent of the parents to refuse it. The court asserted that in applying the balancing test it is important to undertake an evaluation of the risk of the procedure compared to its potential success. It went further to assert that Courts generally consider two main factors. First, the court considers the effectiveness of the proposed treatment and determines the child's chances of survival with and without it. Second, the court evaluates the nature of the treatment and its effect, physically and emotionally on the child. This analysis is consistent with the principle that state intervention in the parent-child relationship is badly justifiable under compelling conditions. The state's interest in forcing a minor to undergo medical care diminishes as the risks of treatment increases and its benefits decreases according to the court.

Courts are careful and have declined in a number of cases to order treatment when such treatment is no more or less likely to benefit the child than the alternate cause of actions

[54] R Heywood, 'Parents and Medical Professionals: Conflict, Cooperation, and Best interests' *Medical Law Review*(2012) (20) 34.
[55]ibid, 36.
[56] 588 A.2d 1108, 1117 (Del. 1991).

chosen by the parents.[57] The Supreme Court in *Weber v Stony Brook Hospital*[58] dismissed the proceedings against Doe's parents' decision to refuse surgery for their infant afflicted with spina bifida, microencephaly, and hydrocephalus, stating that 'the parents' choice of a course of conservative treatment instead of surgery was well within accepted medical standards and [hence]…there was no medical reason to disturb the parents' decision'.

In *Re A (Male Sterilisation)*[59] the patient had been found to lack capacity to litigate and make decisions as to his medical treatment. On the issue of best interest Thorpe LJ had this to say:

> There can be no doubt in my mind that the evaluation of best interests is akin to a welfare appraisal. Pending the enactment of a checklist or other statutory direction it seems to me that the first instance judge with responsibility to make an evaluation of the best interests of a claimant lacking capacity should draw up a balance sheet. The first entry should be of any factor or factors of actual benefit…Then on the other sheet the judge should write any counter balancing dis-benefits to the applicant…Then the judge should enter on each sheet the potential gains and losses in each instance making some estimate of the extent of the possibility that the gain or loss might accrue. At the end of the exercise the judge should be better placed to strike a balance between the sum of the certain and possible gains against the sum of the certain and possible losses. Obviously only if the account is in relatively significant credit will the judge conclude that the application is likely to advance the best interests of the claimant.

The above case dealt with an adult without capacity, nonetheless, its tests for the determination of best interest was adopted in the case of *Re Wyatt (A Child) (Medical Treatment: Parent's Consent*)[60], where the court held that albeit there was a presumption in favour of preserving life, there was sufficient evidence to indicate that life-sustaining treatment would actually work to the detriment of the child. Some parents may wish to prioritise the quality of their child's life over its duration.

Applying the forgoing considerations to the 'best interest standard' in instances where parents and the state disagree as to which course of treatment is in the best interest of a child, it is submitted that the courts should offer both parties, based on the doctrine of fair hearing, the opportunity to give evidence (expert evidence) as to the benefits, dis-benefits, consequences and successes of their proposed form of treatment, and thereafter, undertake an evaluation of the nature, effectiveness and risks of the proposed treatments compared to their chances of success and impact on the child's physical, emotional and mental well-being. The use of *exparte* applications by the state in seeking an order for the desired course of treatment for a child or children should be discouraged, rather the courts in the spirit of fair hearing should provide both parties the opportunity to argue their desired choice of treatment. The

[57] SD Hawkins, 'Protecting the Rights and Interests of Competent Minors Litigated Medical Treatment Disputes *Fordham Law Review*(1996) (64) (4) 2089.
[58]60 N. Y. 2d 208 (1983).
[59][2000] 1 FLR 549 at 560.
[60][2004] EWHC 2247 at [38]-[39].

court is required to 'exercise an independent and objective judgment' while balancing the advantages and disadvantages of treatments.[61]

Parents should not be victimised because of their preference of a form of treatment over another as long as their choice is well within accepted medical standards, and they can provide logical evidence supporting the fact that their preferred choice of treatment is in the best interest of their child or ward. Due to the urgent nature of these treatments it is submitted that family courts should be established as in other climes in each state of the federation to deal expeditiously with such cases involving healthcare providers and parents' conflicts. In cases where courts decide in favour of parents' choice of bloodless medicine and surgery an order should be made directing the hospital to commence such treatment or transfer the child to a hospital that can provide such treatment.

ii. Mentally Disordered Persons

Flowing from the incapacity rule, a mentally disordered person is incompetent and so lacks capacity to give consent to medical treatment.[62] Whether a mentally disordered person can give or withhold consent is dependent upon whether he understands and can come to a reasonable decision as to what is involved in a medical treatment.[63] As explained under the 'mature minor' principle, the competence of a mentally disordered person depends on his ability to understand logically the nature of the proposed treatment and his ability to make rational choices.

The English Mental Health Act provides that a mentally disordered patient may have capacity in law to consent or refuse treatment if he has sufficient understanding.[64] The right of mentally impaired patients to consent to treatment has been upheld in a number of cases. In *Re Maida Yetter*[65] the patient was diagnosed of schizophrenia. She was discovered to have a breast discharge indicating carcinoma or breast cancer. The doctors recommended that a surgical operation be performed on her. But she refused, stating that she was afraid because the death of her aunt followed such a surgery. William J, held that her unwillingness to give consent should not be overridden because even though her position was irrational, it was a competent decision. In a similar case of *Re C*,[66] the court granted an injunction preventing Heatherwood Hospital from amputating C's leg without his express consent. C was a 68 year old man with gangrene in the right foot and the hospital considered amputation. The hospital argued that by virtue of C's chronic mental illness, he had no capacity to make an informed choice. The court held that in determining C's capacity the important question to be decided is whether it has been established that C's illness prevented him from understanding the nature, purpose and effect of the proposed amputation. To arrive at this His Lordship used the three-stage inquiry namely: (i) the patient's ability to comprehend and retain treatment information; (ii) belief in the treatment; and (iii) balance of risks and benefit ratio. Applying this decision making process, the court found that C's mental illness had not displaced his right of self-determination and his choice was informed.

This work aligns with the above decision that a mentally disordered patient who is competent to understand the nature, risks, benefits and consequences of a particular treatment

[61]*Minister of Health v AS* (2004) 29 WAR 19-21.
[62]Emiri(n46) 329.
[63]Skegg(n45) 56-57.
[64]s 57 and 58 Mental Health Act, 1983 (England).
[65](1973) 960 SC 2d 619.
[66][1994] 1 All ER 819.

has the right to consent to or refuse a form of treatment. Thus, a doctor who overrides the informed choice of a competent mentally challenged patient would be liable for battery. On the other hand, if a patient is incapable of making decisions or unable to understand the nature of a treatment due to his mental illness, such decision may be taken on his behalf by proxy. Proxy decision making may be by relatives, courts and others, as long as such decision is lawfully justifiable.[67]

It should be noted that the Mental Health Act of England is inapplicable in Nigeria and the decision of the courts in the above cases are only persuasive and can only guide our courts in reaching decisions in similar cases. The Nigerian Mental Health Bill which was meant to repeal the Lunacy Act of 1958 (which not only disregarded the protection of certain human rights of mentally ill persons but also in many ways was itself responsible for abusing their human rights),was first introduced in the National Assembly in 2003, but was withdrawn in 2009. It was subsequently re-introduced in 2013 and 2016. It was finally passed in December 2020 and July 2021 by the Senate and House of Representatives respectively.[68] The Mental Health Bill has, however, not been signed into law by the President of the Federal Republic of Nigeria and as such does not assume the status of an act of the National Assembly.[69] The proposed bill which deals with treatment of mental patients provides that medical treatment for mental disorder shall require the consent of the patient and the patient has the right to decide whether or not to accept such form of treatment. It goes further to provide that a patient shall not be given any form of treatment unless the medical officer or medical practitioner has certified in writing that the patient is capable of understanding the nature, purpose and likely effects of the treatment and has consented to it. If the medical practitioner certifies in writing that the patient has not consented to the treatment for reason of incapacitation, but having regard to the likelihood of alleviating or preventing a deterioration of his condition, the treatment should be given.

It is submitted that the proposed Mental Health Bill should be speedily assented to by the President. This is of importance because it not only guarantees and protects the right of mentally challenged patients to consent or refuse treatment, but also clearly defines the liability of medical doctors in their treatment of mentally disordered patients in Nigeria.

It is advised that doctors obtain the consent of a surrogate decision-maker, preferably the next-of-kin of the patient before proceeding on a proposed treatment. The surrogate decision-maker as far as is reasonably ascertainable must consider; (a) the person's past and present wishes and feelings, (b) the beliefs and values that would be likely to influence the decision if the person had capacity, and (c) the other factors that the person would be likely to consider if he were able to do so.[70] In cases where the State steps in as *parens patriae* and objects to the decision of a surrogate decision-maker, for instance in cases where the surrogate opts for bloodless medicine and surgery over blood transfusion, the court should likewise as in the case of incompetent minors take evidence from both parties, evaluate same in relation to the benefits, risks, consequences and successes of both forms of treatments and reach an independent and objective conclusion based on the best interest of the mentally incompetent patient.

[67]Emiri(n46) 347.
[68]Policy and Legal Advocacy Centre, 'New Mental Health Bill Puts Human Rights on the Front Burner' *BEAM*(Lagos, 3 September 2021) <https://placbeam.com/2021/09/03/new-mental-health-bill-puts-human-rights-on-the-front-burner/> accessed on 31 May 2022.
[69] ibid.
[70]s 4 (6) Mental Capacity Act 2005 (England).

iii. Unconscious Patients in Emergency Situations

Incapacity of patients can also arise where patients are seriously ill to consent to treatment and yet are neither minors nor mentally incompetent, but are incompetent by reason of their ailment, for instance, unconscious patients in emergency or life-threatening situations. In such situations, treatment may be given without any information or consent if it is necessary to protect the patient's life or health, where a patient is unconscious, intoxicated, and/or disoriented unable to consent or appreciate what is required, the doctor may proceed with the necessary treatment in good faith or for the benefit of the patient.[71] An exception to the doctrine of informed consent arises when the patient is unconscious and there exists genuine emergency, the impracticality of conferring with and obtaining the consent of the patient dispenses the need for it.[72] It follows then that where a patient is comatose or suffering impairment of capacity to consent or refuse treatment it may be better to give attention to the known instinct of survival which can, in a critical situation, alter previously held convictions.[73]

In cases of emergency, before a doctor proceeds with any treatment on a patient unable to give consent, a substitute decision maker, if available should be approached. If, however, such a person is not available, the doctor should do what is essential to save the life of the patient even without consent. Where patients who lack decision-making capacity appoint a surrogate decision-maker, medical practitioners in order to escape liability are bound to make decisions with the patient's legal agent as designated in the patient's advance directive (durable power of attorney for health care or health care proxy).[74] If a patient is in possession of a duly executed advance directive it is the duty of the doctor to act in accordance with the directive in order to escape liability. In the Canadian case of *Malette v Shulman*,[75] a signed advance directive regarding blood use was disregarded by the emergency room doctor. At trial the judge held the doctor liable and awarded $20,000. The decision was upheld in a unanimous decision by the Court of Appeal which held that 'The doctor cannot be held to have violated either his legal duty or professional responsibility towards the patient…when he honors the Jehovah's Witness card and respects the patient's right to control her own body in accordance with the dictates of her conscience'. If the patient has not completed a written advance directive appointing an agent, doctors need to make decisions with a surrogate who should be appointed according to the provisions of the state law in which the care is being provided.[76] In Nigeria, consent for treatment of unconscious patients is obtained from the next-of kin of the incompetent patient.[77] The next-of-kin stands in as the surrogate decision-maker and should base his decisions on what the patient would choose if he were competent to do so, if the patient's views about treatment are unknown, the surrogate's decision should be based on the patient's best interest.[78]

No one can give consent for any treatment on behalf of an adult, but it is advised that doctors should get the consent of the next-of-kin of the patient. In the absence of the next-of-

[71]KK Shaha, AP Patra and S Das, 'The Importance of Informed Consent in Medicine' *Scholars Journal of Applied Medical Sciences*(2013) (1) (5) 456<http://saspublisher.com/wp-content/uploads/2013/10/SJAMS15455-463.pdf> accessed on 31 May 2022.
[72]*Canterbury v Spence* (1972) 464 F.2d 772.
[73]*Re Osborne* 294 A.2d at 374.
[74] AH Moss, 'Patient Selection for Dialysis and the Decision to Withhold or Withhold Dialysis' in C S Wilcox (ed), *Therapy Nephrology and Hypertension* (3rd edn, Saunders, 2008) 946.
[75](1987) 63 O.R (2d) 243.
[76]ibid.
[77]r 19 CME.
[78]Moss(n74) 946.

kin, the most senior doctor in the hospital or institution can give appropriate directive to preserve the life of the patient.[79] In special situations a court order may need to be procured to enable life-saving procedures to be carried out.[80] Such special situations may include situations where decisions taken by surrogates are detrimental to the well-being of the incompetent patient. Doctors in such situations in order to avoid liabilities arising from death or severe injury to the patient should approach the court for an order mandating life-saving procedures to be carried out contrary to the decision of the surrogates. Again the courts should take evidence from both parties, evaluate same in relation to the benefits, risks, consequences and successes of both forms of treatments and reach a conclusion based on the best interest of the incapacitated patient.

CONCLUSION

Bloodless medicine and surgery is a developing branch of medicine gaining wide acceptance around the globe due to the risks and complications associated with the transfusion of allogeneic blood. As discussed in this work, medical practitioners who opt for bloodless medicine and surgery in the treatment of patients after obtaining valid consent cannot be liable by reason of their choice of treatment. Adult patients, competent minors, competent mentally disordered patients and conscious patients possess the right to refuse treatment with allogeneic blood. Same cannot be said of incompetent minors, mentally disordered patients incapable of giving consent by virtue of their illness and unconscious patients in emergency situations. These categories of incompetent patients require consent from parents, guardians, agents, next-of-kin or the state in cases where the best interest of the patient is in dispute.

The work finds that the use of *ex parte* applications by the state in seeking an order for the desired course of treatment for a child or children is in the spirit of fair hearing. It is submitted that in such cases of disputes between the state and parents, guardians or agents of incompetent patients the courts should provide both parties, in the spirit of fair hearing, the opportunity to call expert evidence as to the nature, benefits, consequences and successes of their proposed form of treatment, and thereafter undertake an evaluation of the nature, effectiveness and risks of the proposed treatments compared to their chances of success and impact on the child's physical, emotional and mental well-being. The use of *exparte* applications by the state in seeking an order for a desired form of treatment for incompetent patients should be discouraged. It is further submitted that due to the expeditious nature of such cases family courts should be established just as in other jurisdictions in each state of the federation for speedy dispensation of justice.

[79] r 19 CME.
[80] ibid.