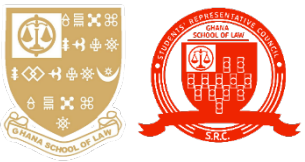
Published 2023



GHANA SCHOOL OF LAW
STUDENT JOURNAL

COMMON SENSE, BOLAM OR MONTGOMERY? IN SEARCH OF AN "APPROPRIATE" STANDARD FOR ASSESSING CONSENT-RELATED MEDICAL NEGLIGENCE IN GHANA

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Publisher
The Students' Representative Council
Ghana School of Law
Accra

http://www.gsljournal.org/

ISSN: 2961-032X
This journal should be cited as (2023) 8 GSLSJ

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COMMON SENSE, BOLAM OR MONTGOMERY? IN SEARCH OF AN "APPROPRIATE" STANDARD FOR ASSESSING CONSENT-RELATED MEDICAL NEGLIGENCE IN GHANA.

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ABSTRACT

Disclosure of material risks associated with medical treatment to obtain patient consent is vital to the doctor-patient relationship. It could be the determining factor between life and death, or between permanent disability and full recovery from medical treatment. On the part of the caregiver, properly obtained consent for medical treatment may offer significant protection against patient lawsuits. In this paper, we explore the legal duty placed on medical professionals regarding disclosure of medical information and obtaining consent for treatment. Particularly, we examine three contrasting tests or standards available to the Ghanaian courts for the assessment of medical negligence claims that turn on patient consent: common sense, Bolam and Montgomery. We observe that the Ghanaian courts have favoured the Bolam test over the common-sense approach adopted in the case of Asantekramo. We further observe that the United Kingdom ("UK") decision in Montgomery's case is yet to receive judicial blessing in Ghana. We recommend that in developing jurisprudence in this area of the law, the Ghanaian courts should lean favourably toward the sound principles animated in Montgomery's case.

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1.0 INTRODUCTION

Information and risk disclosure in medical treatment are important aspects of the doctor-patient relationship. They could be the determining factor between life and death, or between permanent disability and full recovery from medical treatment. Medical professionals are obligated by law and the ethics of their profession to obtain the informed consent of the patients they treat. Informed consent is based on the duty of medical professionals to disclose the necessary information to enable a competent patient to make an informed choice about a medical procedure of their own volition.[1] Under section 97 of the Mental Health Act, 2012 (Act 846), informed consent has been defined as 'an agreement or consent for a procedure given freely without coercion by a person with capacity when the person has been made fully aware of the nature of the procedure, its implications and available alternative.' The Common Law courts over the years have had to address the issue of informed consent in varying circumstances. However, no uniform rule of law appears to have been applied besides the fundamental principle that a competent person must decide what should be done to his own body. The recent UK Supreme Court decision in the case of *Montgomery v Lanakshire Health Board*[2] is however instructive on the issue as it attempts to lay down a general rule as to the scope and extent to which a medical professional is obligated to disclose medical information to his patient to obtain his or her consent for treatment.

In this paper, we explore the legal duty placed on medical professionals in terms of disclosure of medical information and obtaining consent for treatment. We further explore the law on how and what information should be given, and the implications of failing to provide such information. Particularly, we examine three contrasting tests or standards available to the Ghanaian courts for the assessment of medical negligence claims that turn on patient consent. Thus, the common-sense test applied in the Ghanaian case of *Asantekramo Alias Kumah v Attorney-General*[3] is discussed in light of the *Bolam* and *Montgomery* tests applied in the English cases of *Bolam v Friern Hospital Management Committee*[4] and the recent UK Supreme Court decision in *Montgomery v Lanakshire Health Board,*[5] respectively.

2.0 *BOLAM V FRIERN HOSPITAL MANAGEMENT COMMITTEE* (BOLAM'S CASE)

2.1 Brief Facts

John Bolam, the plaintiff, was a salesman who was suffering from depression. He was advised to undergo electroconvulsive therapy (ECT), a form of therapy used to manage some psychiatric conditions. By the procedure, electrodes were to be placed on his head by which he was to have electric current administered to his brain. He signed a consent form agreeing

[1] Paul Appelbaum, 'Assessment of Patients' Competence to Consent to Treatment' (2007) 357 New England Journal of Medicine 1834.
[2] [2015] UKSC 11.
[3] [1975] 1 GLR 319.
[4] [1957] 1 WLR 582.
[5] *Montgomery* (n 2).

to the procedure. At the time, there were differing views among medical professionals over whether relaxant drugs should be provided before the procedure was carried out. A relaxant drug could be administered to put the patient to sleep and to paralyse the muscles to limit movement in the course of the procedure to reduce the risk of fractures. The hospital did not believe that a relaxant drug was necessary, therefore Mr. Bolam was not provided with them. He suffered a bone dislocation and some fractures as a result of the procedure. Mr. Bolam sued claiming negligence on account that the doctor failed to warn him of the risks he was taking when he was consenting to the procedure and that he was not to have anaesthesia. He claimed further that the doctor was negligent in not administering a relaxant drug.

2.2 Holding

The Jury decided in favour of the hospital to the effect that they were not liable for negligence. McNair J in directing the jury to come to a decision stated the following test to apply as follows:

> The real question on which you have to make up your mind on each of the three major points to be considered is whether the defendants, in acting in the way in which they did, were acting in accordance with a practice of competent respected professional opinion ... I myself would prefer to put it this way: *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 art* (Emphasis added).

The court proceeded to rule that, on the evidence provided by medical experts who were called as witnesses in the matter, it was common practice not to provide information or warn the patient of the risks of treatment, especially in cases where the risk of the injury was small, and where the patient does not ask of the medical procedure to be used, as it was in the case of *Bolam*. The test in the *Bolam* case has come to be known as the *Bolam Principle*. The *Bolam principle,* therefore, applies a standard for assessing consent-related medical negligence that is set by and dependent on the opinion of medical professionals. This standard implies that, if in the opinion of a reasonable body of medical professionals, there is no need to disclose a particular medical information or risk to a patient, then a professional should not be held liable for not disclosing same. This standard therefore appears to be more caregiver-centred, rather than patient-centred.

One inherent weakness of the *Bolam* principle is underscored in Justice Date-Bah's observation that 'in Ghana, it is said that health professionals never testify against themselves and therefore there is a real hurdle to litigation of medical malpractice cases.'[6]

[6] University of KwaZulu-Natal, 'UKZN Academic Conducts Medical Law and Ethics Workshop in Ghana' (University of KwaZulu-Natal) <https://ukzn.ac.za/news/ukzn-academic-conducts-medical-law-and-ethics-workshop-in-ghana/> accessed 25 July 2023.

The test in the *Bolam* case was later qualified in *Bolitho v City and Hackney Health Authority*[7] in which the UK House of Lords held that a judge is not entitled to uphold a professional medical opinion if it can be demonstrated that that opinion is not capable of withstanding logical analysis. The House of Lords, however, did not extend this modification to questions of disclosure of risks. Rather, it confined itself to the question of clinical judgment that had been brought before it. In that case, a doctor was summoned to attend to a child suffering from breathing difficulties but failed to do so as her bleep had failed due to low battery. When the child died, his mother argued that if the doctor had attended and intubated the child, he would have lived. The doctor contended that even if she had seen the child, she would not have been intubated. Other doctors gave concurring opinions. The trial judge applied the *Bolam* test and held that there was no breach of duty. This was affirmed by the Court of Appeal and the House of Lords.

3.0 *MONTGOMERY V LANARKSHIRE HEALTH BOARD*

The *Bolam* principle was re-examined and departed from in 2015 by the UK Supreme Court when confronted with another issue that turned on informed consent, in the case of *Montgomery v Lanarkshire Health Board*.[8] The court, in this case, adopted a more patient-centred approach to the disclosure of medical information and risk and placed a greater duty of care on doctors about such disclosures to obtain consent for treatment.

3.1 Brief Facts

The appellant, Nadine Montgomery, was a short and diabetic woman who gave birth to her baby boy at the Bellshill Maternity Hospital, Lanarkshire. At the time, scientific data showed that pregnant women with diabetes were more likely to have large babies with a 9-10% risk that the shoulders of the baby would be too wide to be delivered through the vaginal canal without medical intervention. This delivery risk is called shoulder dystocia. It was the policy of the hospital not to advise routinely diabetic women about shoulder dystocia. The doctor who managed her through delivery, therefore, did not disclose this information to her. It happened that her baby was large and therefore suffered serious disabilities as a result of the vaginal delivery. Mrs. Montgomery argued that she ought to have been advised about the risk of shoulder dystocia and the alternative option of delivery by caesarean section. The overarching question before the court was whether or not the attending doctor breached her duty of care when she failed to disclose the risks of shoulder dystocia.

3.2 Holding

The UK Supreme Court held that the doctor breached her duty by failing to provide the necessary advice upon which Mrs. Montgomery could have made an informed choice as to the method of delivery of her baby. The court ruled that failure to warn a patient of a risk associated with a medical procedure should be considered negligent if the risk was such that it was '*material*' in nature. In paragraph 87 of its judgment, the court stated that the test for

[7] [1997] 3 WLR 1151 [HL].
[8] Ibid.

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.' The basis of the court's decision is captured in the following paragraphs of the judgment:

> An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore 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 or variant treatments…[9]
>
> The 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. The doctor is also excused from conferring with the patient in circumstances of necessity, as for example where the patient requires treatment urgently but is unconscious or otherwise unable to make a decision. It is unnecessary for the purposes of this case to consider in detail the scope of those exceptions.[10]

4.0 CONTRASTING *BOLAM* AND *MONTGOMERY*

The court in the *Montgomery* case believed that the question of whether or not a treatment-related risk is material cannot merely be reduced to percentages and that such risks ought to be weighed on various contextual factors, including the importance of the benefits of the procedure to the patient herself. Indeed, the court held that the significance of a given risk is likely to reflect a composite of factors such as the magnitude, nature, and effect of the risk on the patient as well as the expected benefit of the treatment, available alternatives and the risks associated with those alternatives.[11] In effect, the court adopted the opinion that what goes into materiality is issue-specific, fact-sensitive and is dependent on the peculiar circumstances of the patient. By this decision, the court departed from the *Bolam Test*, which had placed more emphasis on what a competent medical professional would do as an accepted practice. It appeared that the court was now carving a rule around what a reasonable, competent professional would do having regard to the peculiar circumstances of the patient. Of course, the court recognised the '*therapeutic exception*' that a doctor could withhold some medical information from the patient if disclosing same would be detrimental to the health of the patient. However, according to the court, this was merely an exception and could not be the norm or the general rule. In paragraph 75 of the judgment in *Montgomery's* case, the court stated as follows:

[9] *Montgomery* (n 2), para 87.
[10] Ibid, para 88.
[11] Ibid, para 89.

> It has become increasingly clear that the paradigm of the doctor-patient relationship …has ceased to reflect the reality and complexity of the way in which healthcare services are provided, or the way in which the providers and recipients of such services view their relationship. One development which is particularly significant in the present context is that patients are now widely regarded as persons holding rights, rather than as passive recipients of the care of the medical profession.

The court further emphasised in paragraph 78 that 'In relation to risks, in particular, the document advises that the doctor must tell patients if treatment might result in a serious adverse outcome, even if the risk is very small, and should also tell patients about less serious complications if they occur frequently'.

This meant that the patient was to be left to decide what weight or value to place on a medical risk. It is safe to conclude, therefore, that under the Common Law, there is a paradigm shift from the *Bolam Test* regarding cases coming under informed consent. In particular, the UK Supreme Court had redefined the duty of a doctor to his patient regarding the need for informed consent for medical procedures. This duty was 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 or variant treatments.[12] Clearly, there is a shift from the traditional paternalistic approach to a more patient-centred approach to caregiving. Instructively, the court provided a three-step approach to this duty by stating that:

i. The assessment of whether a risk is material cannot be reduced to percentages. No matter the smallest possibility of an event occurring, it should be disclosed to the patient;
ii. The doctor's advisory role involves dialogue by avoiding technical terms and rather aiming to ensure that the patient understands the seriousness of the condition, the anticipated benefits and risks of the proposed treatment and any reasonable alternatives, to make an informed decision; and
iii. The therapeutic exception should not be abused considering that it is a limited exception and may only be activated in limited cases.

In outlining the therapeutic exception, the UK Supreme Court was still minded to make the wellbeing of the patient paramount. The therapeutic exception, also known as therapeutic privilege or therapeutic non-disclosure, is defined as the 'withholding of relevant health information from the patient if non-disclosure is believed to be in the best interest of the patient.'[13] It is mostly deployed when the information that should be disclosed to the patient would psychologically harm the patient which may in turn harm the physical health of the patient. In the case of *Canterbury v Spence,*[14] a US court held that in cases where disclosing

[12] Ibid, para 87.
[13] EB Rubin, 'Professional Conduct and Misconduct' (2013) 118 Handb Clin Neurol 91.
[14] 464 F 2d 772 (1972).

medical information would make the patient so ill or emotionally distraught as to hinder or complicate his or her treatment or disable that patient from making a rational decision, such information could be withheld. The court was, however, mindful to hold further that in such situations, it would be prudent to disclose to a close relative with the view to securing consent to the proposed treatment. In the case of *Sidaway v Board of Governors of the Bethlem Royal Hospital*[15], Lord Scarman stated that the burden of proof is on the doctor to prove that he or she reasonably believed that disclosure of risk would be contrary to the best interest of his client.

As stated in the *Montgomery* case, the therapeutic exception should rarely be used as it is a digression from the fundamental ethical principle of patient autonomy, which promotes respect for the right of a patient to decide on matters that affect their health.[16] The position in *Montgomery* appears to have been necessitated by the emergence of cases in which caregivers have placed little or no premium on patient autonomy.

5.0 *ASANTEKRAMO* (THE *COMMON-SENSE* TEST)

The Ghanaian courts have not had many occasions to address negligence claims bordering on informed consent. We argue, however, that a search of the test applicable to Ghana must begin from the seminal case of *Asantekramo Alias Kumah v Attorney-General*.[17]

5.1 Brief Facts

In *Asantekramo*, the plaintiff was a young married woman of 19 years who was diagnosed with a ruptured ectopic pregnancy at the Komfo Anokye Teaching Hospital. She consented to a surgical procedure to treat her condition. The surgery was successful. However, her right arm became swollen and gangrenous due to an infection she suffered after being transfused an amount of blood through a vein in that arm by the nursing staff. The infection was so serious that the doctors proposed to have the affected arm amputated. The plaintiff claimed that she objected to the amputation on the basis that she saw no reason why her arm should end up being amputated when she reported to the hospital with complaints of stomach ache. According to her, the doctors then obtained the consent of her relatives and amputated her arm a few inches above the elbow. She sued the hospital for negligence.

5.2 Holding

The court, in part, subjected the defendant's medical evidence to common sense and found that the opinion lacked sufficient logical basis to persuade the court. The opinion of the court is captured in the following dictum:

> In the case before me, I think I can as a matter of *common sense* take judicial notice of the fact that persons who go to hospitals with stomach ailment do

[15] [1985] 1 AC 871, HL.
[16] RW Scott, *Promoting Legal and Ethical Awareness: A Primer for Health Professionals and Patients* (Elsevier Health Sciences 2008).
[17] [1975] 1 GLR 319.

not end up with their arms amputated. It is not part of the treatment. Indeed, even a very cursory examination of the evidence of the plaintiff shows clearly that at least something must have gone wrong in the hospital and that that something must be in the peculiar knowledge of the defendant's servants. The circumstance further shows prima facie that that something which went wrong ought not to have gone wrong if those in charge of the plaintiff had not been at some fault of a sort, for prima facie there ought not to be any reason why stomach pains should end up in amputation.[18]

6.0 *ASANTEKRAMO, BOLAM* OR *MONTGOMERY*? EXPLORING A CURRENT GHANAIAN STANDARD

It would appear that at the time *Asantekramo* was decided, the law on the doctor's duty as it relates to patient consent was one that was still being developed in the UK. It can be inferred from the reasoning of the court that emphasis was placed on the scope of consent initially provided by the patient and the apparent departure from such consent by the surgical team through the subsequent amputation. The court's emphasis on common sense shows that there are certain instances where the medical procedure digresses from the ailment complained of, so much that medical expertise is not necessary to prove that the treatment was wrong or unconsented to. Effectively, the court adopted the view that the eventual amputation could not be included in the treatment that the plaintiff consented to and was therefore expected to receive. By this decision, the court was setting a precedent that where a treatment or procedure fell so wide outside the scope of treatment or procedure consented to, it could not be justified within the initial consent given, more so, if the subsequent procedure or treatment arose from negligence. Zutah and others have argued that negligence could not properly be counted as a risk associated with a particular medical procedure, therefore, it does not come within the scope of procedure consented to.[19] According to the authors, it would be wrong and unjust for the courts to adopt the view that a person should not sue a caregiver for negligent treatment only because that person consented to the risks associated with that treatment. The authors' position appears to find expression in section 42 (c) of the Criminal and Other Offences Act, 1960 (Act 29) which provides that 'consent to the use of force for the purpose of medical or surgical treatment does not extend to an improper or a negligent treatment.' This position is further accentuated by the holding of the Supreme Court of Ghana in *Amakom Sawmill & Co. v Mansah*[20] that even where a person has consented to the risk of some harm, he could not be said, either by implication or otherwise, to have consented to harm by negligence.

[18] Ibid 334.
[19] JT Zutah and others, 'Licensed to kill? Contextualising Medical Misconduct, Malpractice and the Law in Ghana' (2021) 1(2) UCC Law Journal 49.
[20] [1963] 1 GLR 368.

In the case of *Frank Darko v Korle-Bu Teaching Hospital,*[21] a young boy reported at the defendant hospital with a complaint of pain in his right knee. He was diagnosed with a torn patella ligament and consented to a surgical procedure to repair the affected ligament. During the surgery, the boy's left knee was rather operated on. When his father sued the hospital for negligence, the High Court applied the *Bolam* principle and found that the hospital could not be held liable. The court believed that the patient had signed a broad consent form which allowed the doctors to apply any necessary measures toward his treatment, so that, if there was any medical indication for the operation of the left knee instead, the hospital could not be held liable for treating it. Indeed, a portion of the signed consent reads as follows: 'I also consent to such further or alternative operative measures as may be found to be necessary during the course of such operation and to the administration of a local or other anaesthetic for the purpose of the same.'

In principle, this case turned on the scope of consent and the question as to whether or not such broad consent to a medical procedure should absolve a doctor from any liability in negligence arising from that procedure. The High Court in its ruling noted that the plaintiff failed to make a case on the scope and effect of the consent signed. We are of the view that it was crucial for the court to ascertain whether the decision to operate on the other leg arose out of necessity and in accordance with the terms of the consent form or out of negligence. It is our opinion that if the latter was the case and the court had adverted its mind to the principle in *Amakom Sawmill* supra, it may have arrived at a different conclusion. It could also have been argued that since the conditions under which he was operated upon were not one of emergency, the team could not have justified their new decision to operate on the other leg out of necessity. Consequently, operating on the other leg was not properly within the scope of the consent given and the surgical team should have discussed the new plan with the patient.

In the case of *Mohr v Williams,*[22] a patient consented to an operation on her right ear. When she was anaesthetised and unconscious, the doctor discovered that the left ear was more seriously diseased. He therefore decided to operate on the left ear instead. Despite the procedure being successful, the patient sued for damages, claiming she had suffered hearing impairment in that same left ear. The court had to address the question as to whether the patient impliedly consented to an operation on her left ear when she consented to an operation on her right ear. It was decided that since there was no evidence of a serious or life-threatening situation with the left ear, the circumstances were such that further consent should have been obtained. Two principles of law are animated in this case. The first is that a procedure that is performed without the consent of the patient is wrongful unless the circumstances necessitate its performance without consent. The second is that the absence of evil intent or negligence on the part of a caregiver is not a defence in cases where further

[21] Suit No. AHR 44/06, 9. Unreported judgment of the Fast Track High Court, Accra dated 24/06/2008; Zutah (n 19).
[22] 104 N.W. 12 (1905).

consent should have been obtained, where the patient is alleging assault or battery for exceeding the consent given. We adopt the view that even if in the case of *Frank Darko,* it was later discovered although before the procedure that the left knee was rather diseased and not the right, or more diseased than the right, the surgical team should have sought further consent if in the circumstances of his case, there was no imminent risk to life.

A different set of events was observed in the case of *Agyire-Tettey and Sodokeh v The University of Ghana.*[23] In this case, the plaintiff's late wife was scheduled for a caesarean section during which procedure her uterine fibroids were also to be removed. According to the plaintiff, his wife had asked the doctors if there were any risks associated with the removal of fibroid during delivery by caesarean section and was told it was a normal and regular practice without any risks. The woman later died of complications relating to the surgery. The plaintiff argued that his wife had consented to the surgery only because they were told that the procedure was something they did regularly and that there would not be any issues with it. The court, however, found on the medical evidence that the doctors had explained the risks associated with the surgery to them. In finding so, and in finding further on the evidence given by the defendants that the doctors had not been negligent in going about her treatment, the court dismissed the allegation against the defendants. This case did not directly refer to the test in *Bolam's* case but it affirmed the case of *Gyan v Ashanti Goldfields Corporation*[24] which had earlier affirmed the *Bolam* principle. Again, the case demonstrates that, where a doctor fulfils his duty to inform, the doctor would be exonerated from liability. Under the Public Health Act, 2012 (Act 851), which is discussed later in this work, patients also have a duty to ask for further clarification and additional information when they do not understand the information provided to them by the doctor regarding their treatment. The case of *Agyire-Tettey and Sodokeh* presented an early opportunity for the Ghanaian court to examine the applicability of the rule in *Montgomery's* case in its jurisdiction. We, however, observe that no such reference was made to it.

In the recent case of *Chinbuah v Attorney-General,*[25] the Accra High Court also found that a medical team at the 37 Military Hospital ignored the wishes of a pregnant woman to be delivered of her baby by caesarean section. According to the hospital, the medical team considered the option of vaginal delivery to be best for the patient. However, the hospital failed to satisfy the court why a caesarean section could not be performed per the wishes of the woman or why vaginal delivery was the best option under the circumstances. The team, having observed that her labour had delayed, gave medication to induce labour. Consequently, she had a traumatic delivery, causing her to have a deformed baby. She also sustained a vaginal injury from which she bled to death. The conduct of the medical team in this case mirrors certain observations in the *Montgomery* case. In *Montgomery*, the doctors attempted to rationalise their conduct in their evidence that ĺf you were to mention to any

[23] Suit No. GJ150/2016. Unreported judgment of the High Court, Accra dated 19th December 2018.
[24] [1991] 1 GLR 466.
[25] Suit No. GJ/378/2021. Unreported judgment of the Accra High Court dated 21 July 2021.

mother who faces labour that there is a very small risk of the baby dying in labour, then everyone would ask for a caesarean section, and it's not in the maternal interests for women to have caesarean sections.' Similar to the situation in *Chinbuah*, the doctors adopted a paternalistic approach to care without regard to individual preference and peculiarities, and without satisfying the court as to why caesarean section could not be done for the patient. Effectively, the patient was denied the opportunity to make an informed choice as to the mode of delivery. In *Chinbuah*, the court held that the medical team had no justification to refuse to grant the patient's request for a caesarean section. Here again, the court relied on *Gyan v Ashanti Goldfields Corporation* supra which had affirmed the principle in *Bolam's* case.

7.0 STATUTORY INTERVENTIONS IN MATTERS OF INFORMED PATIENT CONSENT

Under the Fourth Republican Constitution, the Parliament of Ghana has made notable interventions in matters hinging on informed patient consent. These interventions are provided for in the Public Health Act, 2012 (Act 851) and the Mental Health Act, 2012 (Act 846).

7.1 The Public Health Act, 2012 (Act 851).

The Public Health Act, 2012 (Act 851) prescribes a Patient's Charter.[26] This Charter defines the rights of patients and the patient's responsibilities. The section on the Patient's Rights provides that:

- The patient is entitled to full information on his/her condition and management and the possible risks involved except in emergency situations when the patient is unable to make a decision and the need for treatment is urgent.
- The patient is entitled to know of alternative treatment(s) and other health care providers within the Service if these may contribute to improved outcomes.

Considering the above provisions, the holding in *Montgomery's* case could be conceived as one that significantly mirrors the Patient's Charter. The Charter focuses on the rights of a patient to full disclosure of information related to the person's medical condition and the possible risks associated with it. The therapeutic exception outlined in Montgomery's case further mirrors the Charter. According to the Charter, the patient is entitled to full information on his/her condition and management and the possible risks involved *except in emergency situations when the patient is unable to make a decision and the need for treatment is urgent.* By recognising this, it is noticed that the nature of protection afforded doctors under the therapeutic exception is also enjoyed by medical professionals in Ghana. As it protects medical professionals, it also allows the patient to receive medical attention in an emergency where an informed decision cannot be made at that particular time. The Public Health Act,

[26] Public Health Act, 2012 (Act 851), s 167 (Sixth Schedule).

2012 also provides that there should be a supply of information in clinical trials.[27] It places a duty on the medical practitioner to give full disclosure of the aims, objectives, risks and effects of the clinical trial to enable the patient make an informed decision as to whether or not to participate.[28]

Between *Montgomery's* case and the Patient's Charter, an important distinction can be seen. In *Montgomery's* case, one of the 3 approaches to ensuring compliance with the requirement of patient consent, as stated by the court, was that a doctor must ensure that the information disclosed to a patient is devoid of technical terms to further ensure a well informed and well understood disclosure. In the Patient's Charter, however, this duty is extended and appears to be shared between the patient and the doctor. The Charter provides that the patient's responsibility includes, 'Requesting additional information and or clarification regarding his/her health or treatment, which may not have been well understood.'[29] The Charter provides that where a patient does not understand any information that was provided to him or her, it is up to that patient to take the further step of requesting further information to understand the issue at hand.

7.2 The Mental Health Act 2012 (Act 846)

Section 62 of Act 846 provides for access to information. It provides that, the patient shall have access to information about the mental disorder and treatment plan of that patient. This provision reflects the court's holding in *Montgomery's* case. The section further provides that access to information may be granted or denied by the clinical representative if the information is harmful to the wellbeing of the patient.[30] In paragraph 88 of the judgment in *Montgomery's* case[31], the court stated that 'the 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.' There is a direct relationship between the principle laid down in *Montgomery's* case and Act 846. Again, section 45 (4) of Act 846 provides for patient inclusion in care planning and decision making relating to that patient. Additionally, under section 71 of the Act, a caregiver cannot proceed to conduct a major medical or surgical procedure on a mentally challenged patient without informed consent or the informed consent of a personal representative if that patient is incompetent to give consent.

The observations from these two statutes underscore the fact that the lawmaker considers informed consent as a crucial aspect of medical treatment in Ghana.

[27] Act 851, s 159.
[28] Ibid,158.
[29] Ibid.
[30] Act 846, s 62(3).
[31] *Montgomery* (n 2), para 88.

8.0 CONCLUSION

The Ghanaian courts have had the opportunity to put *Montgomery* to test in at least two cases that turned on informed patient consent– *Agyire-Tettey* and *Chinbuah.* But in either case, the *Bolam* test was favourable to the court in the peculiar circumstances. Again, we observe that the *common-sense* approach adopted in *Asantekramo,* which resonates with the objective or reasonable man's test, has not been affirmed or expressly departed from in subsequent decisions. It is further observed that *Montgomery,* despite its significant positive implications for patients' rights advocacy, is yet to receive judicial blessing in the Ghanaian courts. We note, however, that some of the essential principles espoused in *Montgomery* had earlier been codified in Ghanaian statutes that govern patient information disclosure and consent.

We propose that having regard to the inherent weaknesses of the *Bolam* test, the Ghanaian courts, in developing their own jurisprudence on malpractice matters involving informed consent, must lean favourably toward the instructive decision in *Montgomery*. We recommend that the courts be guided by the existing statutes which animate the sound principles outlined in *Montgomery*.