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THE CONCEPT OF INFORMED CONSENT IN HEALTHCARE DELIVERY IN GHANA: A RHETORIC OR REALITY?

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ABSTRACT

This paper examines the doctrine of informed consent within the Ghanaian healthcare system, interrogating the significant disconnect between its progressive enactment and the practical realities of its implementation. The claim made in the paper is that the complex legal doctrine of informed consent, when transplanted into Ghana's healthcare system, reflects modern patient-centric standards from advanced jurisdictions, yet remains largely theoretical in Ghana. This shortfall is evidenced by a complete absence of judicial precedents and direct jurisprudence on informed consent, amid persistent systemic and socio–cultural barriers. Using a doctrinal research methodology coupled with a socio-legal contextual analysis, this paper analyses primary and secondary legal sources to establish the challenges encountered in implementing the doctrine of informed consent. Although informed consent, as outlined in Ghanaian law, reflects the context in which it has been used and applied in advanced countries, systemic challenges, evidenced by recent data on literacy rates and inadequate doctor-to-patient ratios, are identified as hurdles that render the practical application of the doctrine of informed consent largely aspirational. Ghana's doctor-to-patient ratio falls below the World Health Organisation recommended ratio of 1:1,320. The paper concludes that for informed consent to transition from rhetoric to reality in Ghana, a modified framework of contextualised informed consent is required. This paper proposes measures such as the development of standardised consent protocols for low-literacy populations, the formulation of official guidelines for navigating familial involvement in decision-making, and the introduction of comprehensive language policies in the training of health professionals and medical interpreters.

Keywords: Consent, informed consent, patient autonomy, healthcare delivery, health professionals

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INTRODUCTION

The doctrine of informed consent, deeply rooted in the ethical principle of patient autonomy, constitutes a fundamental tenet of modern healthcare practice and delivery. It mandates that before any medical intervention is performed, a patient must be provided with sufficient material information regarding their condition, the proposed treatment, its inherent benefits and risks and any reasonable alternatives, to enable them to make a voluntary and informed decision.[3] This principle represents a significant shift from historical medical paternalism, where the decision-making resided exclusively with the physician, to a model of shared decision-making that respects the patient's right to self-determination.[4] The doctrine applies in all healthcare interventions such as treatment, examination or clinical trial. Generally, a patient or clinical human subject must be provided with comprehensive information about their health situation, the proposed treatment, and the risks associated with the treatment before consenting to any form of medical intervention or procedure. Any consent obtained by a healthcare professional upon partial disclosure of the patient's health situation or the purpose of the procedure falls short of the requirements of informed consent. The concept of informed consent is a practical exercise of the patient's autonomy or right to self-determination.[5] A competent patient ought to be allowed to willingly subscribe to a particular medical procedure upon careful reflection on the information provided by the healthcare professional.[6]

To be exonerated from liabilities flowing from the absence of consent, a healthcare provider must obtain a patient's consent before carrying out any therapy on him or her. This requirement also applies to human subjects in a clinical trial. Except in an emergency, the patient or clinical participant must be well-informed about their condition, the available treatment options, and the prognosis of each option before

[3] Divine N Banyubala, 'A Form of Consent but Not Informed Consent: Why the Current Ghana Health Service Consent Form is Unsatisfactory' (2011-2012) 25 University of Ghana Law Journal 68.
[4] Ibid.
[5] Lawrence O Gostin, 'Informed Consent, Cultural Sensitivity, and Respect for Persons', (1995) The Journal of American Medical Association, pages 844-845.
[6] Ibid.

their consent can be considered informed.[7] However, there are certain instances where the law will imply consent to treatment, though the same has not been expressly given. For example, when a patient is unconscious and no relative or attendant is available to consent, the health professional must treat the patient without consent based on the doctrine of necessity. The health professional's key consideration is to save the patient's life (sanctity of life), and in some cases, they have the authority to disregard the refusal of treatment by the patient's proxies if that is contrary to the sanctity of life principle.[8]

In Ghana, the doctrine of informed consent has been formally codified into law. The doctrine was first introduced by the Ghana Health Service when it adopted the Patients' Charter in 2002. At the time, the Charter was only a set of guidelines that first recognised the patient's right to full information and consent. This soft law framework was subsequently given a statutory force through its incorporation into the Public Health Act 2012 (Act 851), legally cementing the doctrine of informed consent within the Ghanaian legal system. The statutory language used in Act 851 mirrors progressive, patient-centric standards seen in advanced jurisdictions, suggesting a deliberate legislative intent to align with global best practices. However, unlike these advanced jurisdictions, where the doctrine developed through judicial enforcement of the right to self-determination and case law, in the case of Ghana, the concept is expressly identified as a statutory right of the patient, which does not derive its existence from any tacit interpretation of constitutional provisions.

The concept is noted to function well in developed countries where a greater proportion of the population has formal education and is well-informed about health issues.[9] There is evidence of inhibition on the implementation of informed consent in low literacy jurisdictions.[10] The question then is, how well does the

[7] Alexander F Ghartey, 'A Systematic Review of Patient Perspective on the Informed Consent Doctrine: Ethical and Legal Reflections (2023) 3(1) UCC Law Journal 32 – 56.
[8] *In the Matter of Claire Conroy* 486 A 2d 1209 (1985); *R (On the Application of Pretty) v Director of Public Prosecutions* (2001) 151 NLJ 1572.
[9] Divine N Banyubala 'A Form of Consent but Not Informed Consent" Why the Current Ghana Health Service Consent Form is Unsatisfactory' (2011-2012) 25 University of Ghana Law Journal 68.
[10] Patricia I Gbolo and Mercy Oke-Chinda 'An Analysis of the Doctrine of Informed Consent in Nigeria's Health Care Services (2018) 69 Journal of Law, Policy and Globalization 15 – 25.

concept operate in Ghana, which is known to have a low literacy rate? It is also the case that the concept of informed consent is centred on the individual patient. In this regard, cultures that practice a communitarian system with family participation in individual decision-making, such as Ghana, may resist the full application of the concept. In the specific case of Ghana, health professionals are on occasion compelled to stop treating patients by family members due to financial challenges, without the patient's consent. Additionally, over 80% of patients in Ghana are unaware of their right to informed consent.[11] Institutions, such as the National Commission for Civic Education and Ghana Health Service, are under-resourced and are unable to carry out their core duty of educating the public on their civic and health rights. The dissemination of health information in Ghana is primarily limited to issues related to public health and disease control, with little attention given to educating patients about their rights to informed consent. As a result, most healthcare providers in Ghana disregard the patient's right to informed consent. Healthcare providers in Ghana often cling to their paternalistic ideologies and withhold information concerning patients' health under the guise of acting in the best interest of patients.[12] The Consultation process is intimidating, preventing patients from asking questions about their health condition and the risks involved in going through proposed treatments. Unfortunately, the few patients who attempt to ask questions are often shut down abruptly by some of these health professionals. The situation becomes more worrying when healthcare professionals, who are fully aware of the doctrine of informed consent, impose certain treatments on patients. Although it is revealed that most patients with no formal education prefer that medical professionals make decisions on their behalf,[13] such healthcare professionals must first relay all necessary information to the patient before the patient decides to entrust them with the decision-making authority.

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[11] Acheampong A Oti et al, 'Informed Consent under the Ghana Health Service Patients Charter: Practice and Awareness' (2016) Journal of Biosciences and Medicines, pages 63-69.
[12] Ibid.
[13] Kenneth A Agu et al., 'Attitude towards Informed Consent Practice in a Developing Country: A Community-based Assessment of the Role of Educational Status' (2014) BMC Med Ethics 15; Divine N Banyubala 'A Form of Consent but Not Informed Consent" Why the Current Ghana Health Service Consent Form is Unsatisfactory' (2011-2012) 25 University of Ghana Law Journal 68.

It is clear from observed practices in healthcare delivery regarding the doctrine of informed consent that the wholesale application of the doctrine, conceived and refined in the individualistic, high-resource, and high-literacy contexts of countries like the United States and the United Kingdom, presents a challenge to Ghana. The socio-cultural and infrastructural landscape of Ghana differs significantly from those of these jurisdictions. Ghana is characterised by a communitarian system where family participation in individual decision-making is common,[14] a national literacy rate, while improving, still leaves a significant portion of the population unable to engage with complex written information or information orally given in the English language, and a healthcare system bedevilled by chronic under-resourcing, notably sharp shortage and maldistribution of medical personnel.

The disconnect between the transplanted doctrine of informed consent and Ghana's socio-legal realities creates a legal paradox. The law, as codified in the Public Health Act, regarding patients' right to informed consent is robust and standard, but the conditions necessary for its meaningful exercise are largely absent. The authors, therefore, proposed a modified version of informed consent that will incorporate the cultural, economic, social and educational peculiarity of patients in Ghana and the challenges facing healthcare delivery in the country. There is a significant research gap in this area, as no critical analysis has been conducted on whether the codified doctrine of informed consent in Ghana is a functional legal rule or merely a rhetorical aspiration. The research in this area in Ghana is limited, with a few qualitative and quantitative studies conducted on the awareness of patients regarding the doctrine[15], a cross-country review of patients' perspective on the doctrine[16], and a digestion of the GHS Consent Form and its compliance with informed consent[17]. In the study on patients' awareness of their

[14] Richard Appiah et al., 'Balancing Ethics and Culture: A Scoping Review of Ethico-Cultural and Implementation Challenges of the Individual-Based Consent Model in African Research' (2024) 19(3) Journal of Empirical Research on Human Research Ethics 143 – 172.
[15] Acheampong A Oti et al, 'Informed consent under the Ghana Health Service Patients Charter: Practice and Awareness' (2016) Journal of Biosciences and Medicines, pages 63-69.
[16] Alexander F Ghartey, 'A Systematic Review of Patient Perspective on the Informed Consent Doctrine: Ethical and Legal Reflections (2023) 3(1) UCC Law Journal 32 – 56.
[17] Divine N Banyubala, 'A Form of Consent but Not Informed Consent: Why the Current Ghana Health Service Consent Form is Unsatisfactory' (2011-2012) 25 University of Ghana Law Journal 68.

right to informed consent, it was made clear that many patients have no knowledge of the concept and are therefore unable to assess its application in their engagement with health professionals.

The paper adopts a doctrinal approach which is centred on the analysis of legal principles, rules and concepts found in primary and secondary sources. The study engages in a socio–legal analysis of the doctrine of informed consent. The paper adopts a doctrinal approach because it is the appropriate method for addressing the central theme of the research. Before empirical research can be carried out on the practice of informed consent in health facilities, it is prudent to identify and analyse the requirements of the law on informed consent and juxtapose them with established societal challenges or practices that may hinder the full implementation of the doctrine. The law does not operate in isolation from the society it seeks to regulate. Therefore, socio-economic and public health data are integrated into the analysis not as empirical evidence to test a hypothesis in a scientific sense, but as an essential context to assess the practical feasibility and real-world implications of the legal doctrine being examined. Data on literacy rates, linguistic diversity and health infrastructure are used to illuminate the challenges facing the implementation of informed consent in law. This paper will serve as the foundation for future qualitative or quantitative research to establish how the doctrine of informed consent is implemented in Ghanaian healthcare delivery. Additionally, empirical research would require a longer period to obtain findings, as health research typically requires ethical clearance from Ethics Committees, which can hinder the research's progress. It is, however, conceded that, being doctrinal research, the paper is unable to fully establish all the real and actual practical difficulties that hinder the implementation of the doctrine of informed consent. The paper is unable to capture the lived experience of patients and the nuanced decision-making by professionals in clinical settings regarding informed consent. The paper, therefore, is not an empirical study of informed consent practices and is limited in that regard.

The paper is organised in nine parts, including this part, which is the introduction. In parts two and three, the paper discusses the historical development of the doctrine of informed consent and the distinction between consent and informed consent, respectively. Subsequently, in part four, the paper discusses patients'

autonomy and capacity to consent. In parts five and six, the concepts of informed consent in advanced democracies and informed consent under Ghanaian law are discussed, respectively. Part seven discusses the practical difficulties in applying the doctrine of informed consent in Ghana. Part eight outlines the way forward, and part nine presents the conclusions.

HISTORICAL DEVELOPMENT OF THE DOCTRINE OF INFORMED CONSENT

It is chronicled that the term "informed consent" as a term of art was first used in a medical malpractice case in 1957 by a United States of America (USA) court.[18] Before then, consent to treatment or medical experiment was a developing issue, and the US court in 1914 actually upheld the patient's right to consent to treatment or refuse treatment.[19] Notwithstanding this, the phrase 'informed consent' had not engaged the minds of the courts. Admittedly, various cultures in different jurisdictions practice the doctrine of informed consent; however, the modern concept of it was developed by individuals who drew influence from Western traditions.[20] At the time of Hippocrates, medical paternalism was the recognised practice in healthcare delivery. The Hippocratic Oath at the time provided a written guideline for the conduct of medical professionals, instructing that physicians may conceal sensitive information from patients to provide them with the best care.[21] The rationale was that the physician is in a superior position to make a decision that is in the best interest of the patient since patients were not likely to appreciate their health situations.[22] Subsequently, Henri Mondeville in the 14th century recommended that doctors must act in a way that will earn the confidence of the patient.[23] Though Mondeville did not specifically recommend getting consent from patients before a medical procedure, he appeared to have proposed involvement of patients in health care delivery. The concept of informed consent

[18] Paul G Gebhard, 'Developer of the term "Informed consent"', New York Times (New York 26 August 1997) NYTC. ISSN 0362-4331> accessed 25 March 2022.
[19] *Schloendorff v Society of New York Hospital*, 105 N.E. 92
[20] Ruth R Faden et al, 'A history and theory of informed consent' (1986), Oxford University Press, ISBN 0-19-5036867.
[21] Ibid.
[22] Ibid.
[23] Ibid.

was proposed in the 18th century by Benjamin Rush, who advised health professionals to share as much information as possible with patients. According to Rush, doctors must educate the public and respect a patient's informed decision to accept or refuse a therapy.[24] He, however, contradicted himself when he subsequently delivered a lecture where he recommended that patients should strictly obey their physician's orders.

The concept of informed consent has little to no place in ancient medical practice. The situation was not different in the practice of clinical trials involving human subjects. The participants were kept in the dark as to the negative effects of such trials. A pertinent case is the Tearoom Trade case, where the American psychologist, Laud Humphreys, researched male homosexuals without the subjects' consent.[25] Though the concept of informed consent engaged the minds of academicians and the courts in ancient times, it did not receive statutory backing until the adoption of the German Government guidelines on human experimentation in 1931. Regulation 1 of the 1931 guidelines stipulated that patients must provide unambiguous, informed consent before any diagnosis, treatment, or experiment could be carried out on them.[26] The need for involvement of the patient or participant in medical treatment or clinical trial was made pronounced during the Nuremberg trial when it was revealed that medical professionals had abused and breached the trust reposed in them and followed the instructions of the Nazi government. It was discovered that healthcare professionals flouted the guidelines on human experimentation and engaged in certain inhumane treatment of patients and human subjects, motivated by the Nazi government's political ideologies. [27]

The shocking revelation of the Nazi human experiment during the Second World War awoke the world and gave rise to the Nuremberg Code in 1947. Among its principles, the Nuremberg Code provided detailed guidance on the principle of informed consent. The code requires a voluntary, well-informed and understanding consent of a participant in a clinical trial. Much later, the infamous Tuskegee

[24] Ibid.
[25] Babbie Earl, *The Practice of Social Research* (12th edn, Wadsworth 2010).
[26] Guideline on Human Experimentation 1931 Regulation 1.
[27] Nuremberg Doctor's Trial, BMJ 1996;313(7070):1445-75.

Syphilis study of the Public Health Service Department of the United States government from 1932 to 1972, which involved Negroe males as subjects without their informed consent, led to the issue of the Belmont report by the United States in 1979.[28] In that report, three main ethical principles were highlighted in the conduct of research involving human subjects. Thus, respect for persons, beneficence and justice.[29] Respect for persons has embedded in it the right to an autonomous decision by a prudent or reasonable patient to enrol on clinical research after a full understanding of the risks and benefits involved. Subsequently, the Helsinki Declaration of the World Medical Association reiterated the requirement of informed consent from subjects in clinical trials. It is provided under the said declaration that every individual who is capable of consenting to a particular experiment must do so voluntarily.[30] The declaration requires the physician to make full disclosure as to the methods, aims, funding and consequences of the experiment.[31] Such a physician must further ensure that the participants understand the information before consenting to the experiment.[32]

The principle of informed consent has become more refined in the 20th century and has continued to improve to the present day. It is noted that the concept still faces challenges, such as cultural, environmental, and demographic limitations. The concept of informed consent flourished and became well recognised upon the collapse of medical paternalism and the emergence of patient autonomy. Patient autonomy is the bedrock on which informed consent is nurtured.[33] It is revealed that some patients endorsed partial disclosure of their medical information, while the majority of patients in Ghana still wish to entrust every medical decision to the healthcare professional.[34] The recognition of informed consent first appeared in the Patients' Charter of the Ghana Health Service. This was merely a soft law providing guidelines to health facilities to strive for promoting patients'

[28] The Belmont Report 1979.
[29] Ibid.
[30] World Medical Association Declaration of Helsinki 1964 (as amended) s 25.
[31] Ibid s 22.
[32] Ibid (n 12).
[33] T L Beauchamp and J F Childress, *Principles of Biomedical Ethics* (Oxford University Press 2009).
[34] Acheampong A Oti et al, 'Informed Consent under the Ghana Health Service Patients Charter: Practice and Awareness' (2016) Journal of Biosciences and Medicines, pages 63-69.

participation in medical treatment. Subsequently, the right to informed consent was given legal force in both the Mental Health Act 2012[35] and the Public Health Act 2012[36]. The authors will, in the next section, draw some distinctions between consent and informed consent, although both terms are often used interchangeably.

DISTINCTION BETWEEN CONSENT AND INFORMED CONSENT

In contemporary medicine, consent and informed consent are two distinct terminologies and are used in different contexts. The concept of consent in medical procedures originates from the disciplines of tort law and criminal law. The idea of the sanctity of a person and the protection of his bodily integrity necessitates the requirement of his consent before any touch on his person. In the law of torts, the absence of this consent results in trespass on the person who is so touched, like tortious battery. In criminal law, this amounts to assault. This understanding of the implication of intrusion on the person's bodily integrity without his consent compels medical professionals in health care delivery to solicit the consent of the patient before any intrusive procedure is conducted on him. In the words of Cardozo J, *"a healthcare professional who fails to comply with this basic and preliminary procedure is liable in tort for battery and in criminal law assault."*[37]

Informed consent, on the other hand, extends beyond consent simpliciter in health care delivery. The concept of informed consent implies both the guarantee of the patient's right to self-determination and the healthcare professional's duty to disclose material information to the patient. The concept imposes a duty on healthcare professionals to ensure that patients understand the procedure they are undergoing.[38] It is not just a mere procedure in compliance with the patient's right to his bodily integrity, but rather a professional duty which must be discharged in accordance with the requisite professional standard. The patient may give consent to a medical procedure, but it may still fall short of the requirement for informed consent. A medical professional's failure to ensure that the patient gives informed consent may be held liable for negligence, but not battery, as in the case of consent.

[35] Mental Health Act 2012 of Ghana.
[36] Public Health Act 2012 of Ghana.
[37] *Schloendorff* (n 18).
[38] Lawrence O Gostin, 'Informed Consent, Cultural Sensitivity, and Respect for Persons', (1995) The Journal of American Medical Association, pages 844-845.

It thus appears that, while consent is prevalent at the complaint and diagnostic stages, informed consent is the required concept at the advice and treatment stages. In summary, the distinction between consent and informed consent lies in the amount of information given before each is obtained or the consequences of the failure to obtain each of them.

As indicated earlier, the concept of informed consent rides on the ethical principle of patient autonomy. It is necessary, therefore, to give a brief discussion of the concept of patient autonomy vis-à-vis informed consent.

PATIENT AUTONOMY AND CAPACITY TO CONSENT

The fabric of the concept of informed consent is the ethical principle of patient autonomy.[39] In other words, the enforcement of the patient's right to give informed consent is a recognition of his autonomy. There has been a significant shift in the doctor-patient relationship from its former paternalistic approach to one that recognises the importance of an informed and autonomous patient.[40] This drastic shift in the locus of decision-making from the doctor to the patient has been heavily reinforced by the legal requirement for informed consent.[41] Patient autonomy guarantees his right to self-determination. However, a patient's right to self-determination is only exercisable by a competent patient.[42] Thus, patients who are deemed to have understood the nature of their health condition and the effect of their decision are competent to exercise their autonomy. It is posited by some scholars that if the depth or range of the information is insufficient, any decision taken by the patient based on such information will not be an autonomous one.[43] To some scholars, patient autonomy includes the rights of individuals to make informed decisions about their medical care.[44] A competent patient exercises his

[39] Lawrence O Gostin (n 38).
[40] Raisa B Deber et al, 'Do People want to be Autonomous Patients? Preferred Roles in Treatment Decision-making in Several Patient Populations' (2007) Vol 10 Issue 3 Health Expectations: An International Journal of Public Participation in Health Care and Health Policy 248-258.
[41] Ibid.
[42] Ibid.
[43] N Hoppe and Jose Miola, *Medical Law and Medical Ethics* (Cambridge University Press 2014) 75.
[44] Leslie J Blackhall et al, 'Ethnicity and Attitude Towards Patients' Autonomy' (1995) 274(10) JAMA 820-825. doi:10.1001/jama.1995.03530100060035.

autonomy by making decisions that determine the course of his life. It does not matter if the decision appeared absurd to the medical professional. It is for the purpose of empowering a patient to objectively exercise his autonomy that the law and ethical principles require that he be given the necessary information concerning the treatment, alternatives, and the risks involved. A person who is not autonomous cannot exercise his or her right to give informed consent to a medical procedure. In such a case, a healthcare attorney or a related person must assume the right of such a person and give informed consent. In such an instance, a person, such as an infant or a person of unsound mind, who is bereft of autonomy must draw on the autonomy of a surrogate to enjoy his or her rights of informed consent. It is, therefore, not in dispute that the ethical principle of patient autonomy operates concurrently and in an inter-relational manner with the patient's right to give informed consent to medical treatment. What then constitutes informed consent, or better still, what elements must be present to make consent an informed one? In the next section, the elements of informed consent will be discussed.

THE CONCEPT OF INFORMED CONSENT IN ADVANCED DEMOCRACIES

As already mentioned, informed consent was first recognised in medical experimentation during the Nuremberg trial in 1947. However, informed consent in its modern form was outlined in the Declaration of Helsinki, published in 1964. It has been established that the enforcement of the elements of informed consent comes with the requirement to follow due process.[45] Informed consent is usually considered to be the process whereby explicit communication of information is provided, which would be relevant for a patient or an experimental subject to decide whether or not to have a particular treatment or to participate in a particular experiment.[46] For consent to constitute an informed one, it must meet the following elements[47];

[45] Allen R Dyer and Sidney Bloch, 'Informed Consent and the Psychiatric Patient' (1987) Vol 13 Journal of Medical Ethics 12-16.
[46] Ibid.
[47] Ibid.

a. The patient must be informed, i.e. the health care professional must relay all the information in relation to the patient's condition, treatment options, risks and benefits.
b. The patient must be competent, i.e. the patient must be able to decode and understand the information as given.
c. The consent must be voluntary.

Similarly, it is posited that the essential elements of valid consent to treatment are as follows:[48]

(a) The patient must have sufficient understanding, variously described as mental capacity or mental competence, to make the decision;

(b) The patient must consent to (or refuse) the treatment out of his own free will, with no duress or undue influence; and

(c) The patient must have been given sufficient information about the proposed treatment.

The concept of informed consent in clinical trials and medical treatment is argued to have six basic elements that underline it. They are as follows: (a) a fair explanation of the procedure to be followed, and its purposes, including identification of any experimental procedures; (b) a description of any attendant discomfort and risk reasonably to be expected; (c) a description of benefits to be expected; (d) a disclosure of any appropriate alternative procedure that might be advantageous; (e) an offer to answer any inquiries concerning the procedures; (f) an instruction that the person is free to withdraw his consent and to discontinue participation from the project or activity at any time without prejudice to the subject.[49]

The patient must, therefore, be able to receive and assimilate the information provided by the medical professional. What then happens if the patient is incompetent or suffers from some intellectual or physical disability that deprives him or her of understanding the information provided by the medical professional?

[48] Marc Stauch et al., *Sourcebook on Medical Law* (2nd edn, Cavendish Publishing Limited 2002).
[49] Helsinki Declaration of the World American Association, Rules and Regulations 1975.

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Also, what if, based on the economic situation of the country, the patient, in exercising his right of self-determination, chose a procedure not available in the particular health facility? The author will return to address these questions in due course, but it is essential to discuss the Ghanaian version of informed consent, or consent in general.

THE CONCEPT OF INFORMED CONSENT UNDER GHANAIAN LAW

Although the concept of informed consent gained prevalence under common law in the 19th and 20th centuries, it did not undergo formal codification in Ghana until the Ghana Health Service (GHS) formulated the Patients' Charter in 2002. The Charter provided for the rights of the patients and, as part of those rights, codified the concept of informed consent in the following terms;

> The patient is entitled to full information on his/her condition and management and the possible risk involved except in emergencies when the patient is unable to make a decision and the need for treatment is urgent."

It is further provided that *the patient is entitled to know of alternative treatment(s) and other health care providers within the Service if these contribute to improved outcomes.* The idea behind formulating the Patients' Charter is great, but its nature as a guideline and/or soft law leaves much to be desired. To address this weakness, the Patients' Charter, as formulated in 2002, was subsequently incorporated into the Public Health Act 2012 (Act 851) to give it the force of law. The Patients' Charter reproduces and incorporates the doctrine of informed consent in the sixth schedule of Act 851, specifically in regulations 2 and 3. The text of the said regulations connotes the following as the elements of informed consent;

a. The patient must be capable of consenting to or refusing treatment.
b. The patient must be provided with all necessary information about their condition, management, and the associated risks.
c. The patient must be told of alternative treatments and the benefits of each treatment option.
d. The patient is entitled to consent or refuse the treatment.

The Patients' Charter has been in force since 2012, but no single case has been decided in the Ghanaian Courts in relation to this Charter. Awareness of the existence of the Patients' Charter is in doubt. A study conducted in 2012, 10 years after the introduction of the Patients' Charter as Ghana Health Service (GHS) guidelines, revealed that the majority of patients had no knowledge of the existence and/or the content of the Patients' Charter.[50] This paper will discuss how a patient's demographic makeup may have an impact on the exercise of his or her right to informed consent.

Also, the Mental Health Act 2012 (Act 846) further strengthened the concept of informed consent by broadening the scope of persons who are entitled to informed consent in healthcare delivery. The Act provides under section 60(3) as follows;

> A person with a mental disorder shall not be used for teaching and research purposes without informed consent, and where that person is incapable of giving informed consent, the consent shall be given by the personal representative of that person.

Act 846 further defined informed consent in section 97 as follows;

> Informed consent means 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 alternatives.

Though the doctrine is a legal rule under the Public Health and Mental Health Acts and can be founded on constitutional rights such as the right to self-determination, the legal terrain for its enforcement remains uncharted in terms of judicial precedent. This absence of case law is, in itself, a crucial finding, suggesting that the statutory rights have not been actively litigated or enforced. Unlike in the United Kingdom, where numerous cases, such as Montgomery v. Lanarkshire Health Board [2015] UKSC 11, have clarified the scope and nature of the doctrine, in Ghana, there is no reported case from any court of competent jurisdiction where the principle has been duly applied. This jurisprudential silence suggests several

[50] Lily Yarney et al., 'Operationalization of the Ghanaian Patients' Charter in peri-urban Public Hospital: Voices of Healthcare Worker and Patients' (2016) International Journal of Health Policy and Management 525-533.

potential factors: a lack of patient awareness of these rights, cultural barriers to litigation against medical professionals, or a combination thereof.

From the above, it is evident that the Ghanaian position on informed consent is a direct adaptation of the concept as practised in advanced countries such as the U.S. and the UK. The question, therefore, is whether Ghana has a well-structured healthcare system like those in advanced countries to implement the doctrine of informed consent wholesale? Are patients in Ghana well-informed as far as their health conditions are concerned? Can medical professionals translate or break down medical jargon into the local dialect or simple language for their patients who are largely not literate? The next section will highlight some practical challenges in implementing the concept of informed consent in Ghana.

PRACTICAL CHALLENGES IN THE APPLICATION OF THE CONCEPT OF INFORMED CONSENT IN GHANA

While Ghana's legal framework for informed consent is doctrinally sound and aligned with modern international standards, the practical implementation is severely undermined by a convergence of systemic deficits and socio-cultural norms. These barriers create a wide gap between the rights articulated in Act 851 and the reality of patients in healthcare delivery. A critical examination of these challenges, supported by data, is essential to understanding why the law remains largely a rhetorical ideal.

The concept of informed consent presupposes that a patient can receive, understand and process complex medical information to make an autonomous decision. In Ghana, this fundamental prerequisite is compromised by significant challenges related to literacy and language. Medical professionals in Ghana are bedevilled with many impediments in explaining medical terms to their patients, especially in translating medical jargon into the local language for their patients' understanding.[51] The 2021 Population and Housing Census of Ghana reveals a national literacy rate (for persons aged six and above) of 69.8%.[52] While this is an

[51] Acheampong A Oti et al, 'Informed Consent under the Ghana Health Service Patients Charter: Practice and Awareness' (2016) Journal of Biosciences and Medicines 65.
[52]statsghana.gov.gh/gssmain/fileUpload/pressrelease/2021 PHC General Report_181121, November 2021 (retrieved on 28/08/25).

improvement, it still means that nearly a third of the population (30.2%) is not literate in any language. The disparity between urban and rural areas is stark, with urban literacy at 80.6% compared to just 55.2%.[53] This data indicates that a substantial portion of the patient population, particularly in rural communities, cannot engage with one of the primary tools of informed consent: the written consent form or information orally given in the English language. Most health facilities provide consent forms written in the English language, often without the legally required jurat clause under the illiterates' Protection Act [54], rendering such forms legally questionable and difficult to understand for a significant number of patients.

The challenge is compounded by Ghana's linguistic diversity. With over 46 indigenous languages spoken, effective communication between health professionals and patients who do not speak the same indigenous language is hindered. Health professionals are often posted to regions or communities where they do not speak the local dialect, forcing them to rely on ad hoc interpreters – often family members, other hospital staff, or non-verbal communication. This process is fraught with the risk of misinterpretation, omission, and breaches of confidentiality, making it highly unlikely that the nuanced information required for true informed consent is accurately conveyed. In 2016, the Kwame Nkrumah University of Science and Technology, in collaboration with the Ghana Health Service, launched the 'Twi' Medical Glossary in an attempt to solve the communication problem. This glossary provides local names of diseases in the 'Twi' language to curb the language barrier between healthcare professionals and patients. This initiative is laudable, but it is inadequate considering the fact that 'Twi' is just one of the languages spoken in Ghana, and that informed consent goes beyond patients knowing the disease they are suffering from. Consequently, many patients give consent without a genuine understanding of the procedure, its risks, or the available alternative treatments.

Secondly, the deficit in the doctor-to-patient ratio, scarcity of health resources, and time constraints hinder the full implementation of the doctrine of informed consent

[53]statsghana.gov.gh/gssmain/fileUpload/pressrelease/2021 PHC General Report_181121, November 2021 (retrieved on 28/08/25).
[54] Illiterates Protection Act 1912 s 4.

under the law.[55] The process of obtaining meaningful informed consent is time-intensive. It requires a dedicated dialogue between the health professional and the patient, allowing for explanations, questions and deliberations. The current state of Ghana's healthcare system nearly renders such a dialogue near impossible in most public hospital settings. The country faces a critical shortage and maldistribution of healthcare professionals. According to 2022 World Health Organisation (WHO) data, the doctor-to-patient population ratio in Ghana is 1:6,993[56], a ratio above the WHO-recommended ratio of 1:1,320. As a result of this shortage in health personnel, time allocated to each patient in the consultation room is minimal, making it impractical to spend so much time on one patient explaining medical information to him or her as required by the concept of informed consent. The problem is exacerbated by severe geographic inequality; staggering 42% of all doctors in the country are concentrated in the Greater Accra Region alone, leaving vast rural areas critically understaffed. This puts extreme pressure on the limited number of healthcare professionals, resulting in minimal time allocated to each patient consultation. In such an environment, the legal requirement to provide full information on conditions, risks and multiple treatment alternatives becomes practically unenforceable. The consultation process is often reduced to a rapid diagnosis and prescription, with little to no room for the shared decision-making process that informed consent demands. Furthermore, resource scarcity means that even if a doctor could discuss possible alternative treatments, many of those options may not be available at a particular facility or even in the country, making the discussion a purely theoretical exercise.

Thirdly, the doctrine of informed consent is predicated on an atomistic, individualistic conception of autonomy, where the competent adult patient is the sole decision-maker. This model is the opposite of Ghana's communitarian and family-oriented systems. In Ghana's cultural context, as in all African countries, an individual's identity is deeply intertwined with their family and community, stemming from concepts such as Ubuntu. Major life decisions, including those related to health, are often made collectively. Studies on African cultures show a

[55] Ibid (n 52).
[56] <https://data.who.int/countries/288> accessed on 1 September 2025.

strong preference for family involvement in medical decision-making.[57] The family unit, rather than the individual, is often seen as the primary locus of decision-making authority, with hierarchical structures where a spouse, parent, or eldest son may take the lead. This can manifest as relatives meeting with physicians independently, receiving information on the patient's behalf and providing consent for treatment. This peculiar cultural setup of Ghanaian society poses a significant challenge to healthcare providers who are legally bound to obtain consent from individual patients. They are often caught between respecting the patient's statutory rights to autonomy and adhering to the family's cultural expectations. Moreover, the 1992 Constitution of Ghana recognises customary law as a form of law that is generally embedded in cultural practices. The communitarian nature of Ghana, in the context of Ghanaians' culture, has a constitutional backing [58]

While the law must ultimately uphold the competent patient's decision, even against the wishes of the family, rigid application of the individualistic model without acknowledging the cultural importance of the family risks alienating patients and their support system.

Lastly, but not least, it is still a common practice in Ghana, where patients often prefer medical decisions to be made on their behalf by health professionals due to the trust and confidence they have in them. On the other hand, those who are minded to make their own decisions are unduly influenced by these medical professionals or their family members. As such, the voluntariness of giving informed consent is often lacking.

What, then, is the way forward for healthcare delivery in Ghana? Do we need a modified version of informed consent that takes into account the patient's demographics, cultural background, and the country's economic situation?

[57] Ibid.
[58] The 1992 Constitution of Ghana, article 11.

THE WAY FORWARD IN APPLYING THE CONCEPT OF INFORMED CONSENT IN GHANA

Since the wholesale adoption of the concept of informed consent poses numerous challenges in its application in Ghana, it is suggested that some modifications to the concept be made to facilitate its effective application in Ghana. For the doctrine to become a meaningful right of patients, it must be adapted to Ghana's unique context. This requires a multi-faceted approach involving conceptual reframing, practical policy implementation by health authorities, educational reforms and targeted legislative action.

The paper proposes a modified conceptual frame of 'contextualised informed consent'. This model will not abandon the core ethical principles of autonomy, beneficence, and justice, but will rather apply these principles in a manner that is sensitive to Ghana's socio-cultural and systemic realities. Health professionals must take into consideration Ghanaian cultural practices and belief systems in applying the concept. This is because the focus on the individual patient in applying the concept is inconsistent with Ghana's communitarian and family-oriented system of living. This concept emanates from the theory of relational autonomy, which acknowledges that for many individuals, decision-making is a socially embedded process. Like other African countries, Ghana places so much importance on the family in decision-making concerning any family member. As such, any informed consent or refusal of the patient without any input from the family will erode the relevance of the family in the lives of its members. However, in the event of conflicts between the wishes of the patient and his family, that of the patient must prevail. This is because Article 30 of the 1992 Constitution provides that no person should deprive a patient of medical treatment based on beliefs. It is believed that this approach to obtaining informed consent in Ghana is more pragmatic and achievable than the wholesale transplantation of the doctrine, which is purely rhetorical or aspirational. It is recommended that the Ghana Health Service develop a standardised, culturally sensitive consent protocol taking into consideration the low-literacy population of Ghana and best practices.

Also, considering the number of Ghanaians with no formal education and the fact that most healthcare professionals are posted to areas where they do not understand the local dialect, there is a need to be liberal in the application of the concept of

informed consent in Ghana. The 2021 Population and Housing Census of Ghana revealed that one in five persons aged three years or older has never attended school. Also, over forty-six indigenous languages are spoken in Ghana. If the concept is strictly applied in Ghana as it is conceived, healthcare delivery will be onerous, as it would be challenging to ensure that patients understand the medical information related to them before they consent to treatment. In fact, even with the few patients with formal education, it is a challenge to break medical jargon into simple language for their understanding. It is, therefore, possible that most patients consent to treatment procedures without actually understanding the information the medical professional gives. It is recommended that medical training inculcate language policies that promote the use of simple and everyday vocabulary. Health professionals should also adopt the 'Teach-back' method to verify patients' understanding by asking patients to explain the information back in their own words. The shortage of health professionals must be curbed by the government by increasing the intake of trainees in health educational institutions, and they should be promptly posted to health facilities upon completion of their training to improve the doctor-to-patient ratio in the medium to long term.

In addition to this, the Ghana Health Service and all the Health Professionals regulatory bodies should adopt a policy of training medical interpreters to overcome the linguistic barrier. These neutral medical interpreters, rather than untrained family members, will provide accurate interpretations, ensuring confidentiality and allowing the patient to ask sensitive questions.

The paper also recommends a review of the curriculum for training health professionals to include mandatory in-depth modules on health law and ethics that go beyond abstract principles. The training should utilise case-based learning to address the specific challenges of obtaining consent in the Ghanaian context, including dealing with low literacy rates, cultural norms, and resource constraints.

Similarly, despite various economic constraints, the information on treatment options should still be comprehensive, although some options may not be available at that health facility or in Ghana. The patient's right is to know all the treatment options, both within and outside, to make an informed decision. If there must be a balance between time spent with each patient and the number of health care professionals available in a facility, a guideline should be adopted by the Ghana

Health Service or health facilities in order not to sacrifice the patient's right to informed consent entirely on the grounds of a lack of personnel.

CONCLUSION

The doctrinal research undertaken in this paper sought to critically evaluate the status of informed consent in Ghana's healthcare system to establish whether its implementation is a reality or merely on paper. The paper made the following findings:

Firstly, Ghana's legal framework, through the codification of the Patients' Charter in the Public Health Act 2012, has formally adopted the doctrine of informed consent in its modern and progressive form, creating a robust set of legal rights on paper.

It is also revealed that informed consent, as a legal concept in Ghana, suffers from a vacuum of judicial interpretation, as no reported case law directly addressing the doctrine has been found. This creates uncertainty as to its practical legal force in Ghana.

Finally, the implementation of informed consent in Ghana is significantly hindered by systemic and socio-cultural barriers, including widespread low literacy, linguistic barriers, a severe shortage of healthcare professionals, and a cultural tension between individualistic legal norms and communitarian family values.

It is clear from the above that informed consent is important since it protects the patient's right to self-determination and participation in medical decision-making. While Ghana possesses a modern and doctrinally sound legal framework for informed consent, the doctrine remains, for the vast majority of patients, a rhetorical ideal rather than a lived reality. The transplantation of the doctrine from a high-resource, individualistic, and Western-cultured jurisdiction into a socio-legal jurisdiction such as Ghana resulted in the doctrine being a rhetoric rather than a reality in Ghana.

The paper therefore proposes a contextualised model of informed consent that is both doctrinally rigorous and deeply attuned to the specific realities of Ghanaian socio-cultural realities. Ultimately, charting a path from rhetoric to reality for informed consent in Ghana is not just a matter of legal interpretation, but a

fundamental challenge of building a more equitable and responsive healthcare system.

The gap between law and practice highlights the need for a more holistic approach to the health sector and health education reforms. There must be a concerted effort from the Ministry of Health, through the Ghana Health Service and professional bodies, to create an enabling environment where patients' right to informed consent is not merely rhetoric but rather a functional reality. The appropriate infrastructure, human resources and culturally competent policies must be put in place to make informed consent in Ghana a reality.

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